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The effect of internalized homophobia and feminist identity on utilization of health services: A Canadian lesbian perspective.

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The Effect of Internalized Homophobia and Feminist Identity on Utilization of Health Services: A Canadian Lesbian Perspective

by

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ABSTRACT

Many lesbian women underutilize the health care system. In fact, some theorists have suggested that lesbians are shifting away from using traditional care toward using nontraditional care to meet their health needs. This study tested the effect of internalized homophobia (IH) and feminist identification on health care utilization and on the use of nontraditional care. Questionnaires were completed by 156 Canadian lesbian women recruited through a snowball sampling technique and through specialized Canadian media (e.g., electronic listserves, lesbian/gay publications). Both IH and adherence to feminist ideology significantly predicted utilization of health services and use of nontraditional care ($p < .01$). Lower levels of IH and higher levels of feminism were associated with more frequent utilization of health services. However, perceived approachability of health care providers mediated the relationship between IH and utilization. Lower levels of IH and higher levels of feminism also significantly predicted more frequent use of nontraditional care. These findings suggest that a feminist identity fosters, and internalized homophobia impedes, optimal utilization of health services.

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TABLE OF CONTENTS

APPENDIX PAGE

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

Introduction

The health of lesbian women[1] has been a neglected topic in health research – particularly in women's health research. Health research that does include lesbian women has consistently found that this subgroup of women underutilizes the health care system. It has been suggested that lesbian women avoid or delay seeking health care as a result of the heterosexist assumptions that they face within health care environments, and fear of discrimination or negative reactions by health care practitioners (HCPs) (White, 1998). Typically, interactions within health care environments leave the health needs of lesbian women unmet or inadequately addressed. This may result in dissatisfaction with traditional health care which in turn may lead lesbian women to seek alternative forms of care (Trippet & Bain, 1992).

It is important to gain an understanding of which factors may foster and which factors may impede optimal utilization of health services for lesbian women. What accounts for the variance among lesbian women's health care utilization rates? What feeds susceptibility and what promotes resilience to a commonly hostile environment (Perkins, 1995)? Research has alluded to, but has not explicitly tested, at least two possible factors that may contribute to the noted differential utilization rates.

For some lesbian women internalized homophobia (IH) may be considered a potential health risk that operates by creating a psychological barrier to health seeking behaviour. In fact, in October, 1998, Charlotte Patterson on behalf of the American Psychological Association (APA), delivered testimony to the Institute of Medicine (IOM) which outlined a series of lesbian health research priorities (Patterson, 1998). Among them was the necessity to investigate the effect of IH on health and on the underutilization of health services.

Another potential factor that may influence health care utilization is a feminist self-identity, or adherence to feminist ideology. Adopting a political stance that espouses equality and self-advocacy may transfer over to the health care arena (Matthews, 1998) to a degree that may offset the negative effect of systemic bias. For example, feminists may seek, or even demand, respectfulness in health care environments. In addition to affecting one's health care expectations and interactions directly, a feminist identity may also run counter to, or work toward decreasing IH.

The present study examined the effect of IH and feminist identification on the utilization of health services by lesbian women. Additionally, it explored whether these variables affected the type of health care (i.e., traditional versus non-traditional / alternative care) that lesbian women used.

Feminist Approaches to Women's Health

We cannot have a complete picture of women's health and of women's health issues without taking into account "the social, political, and economic forces influencing the health of women" (Lempert, 1986, p. 255). A feminist approach to women's health care builds in an awareness of the relevance of socialization and of patients' individual social realities while also remaining mindful of the process of medicalization that brings with it the tendency to define everything in strictly biomedical terms (Van den Brink-Muinen, 1998). Our social circumstances shape our lives in many important ways (Perkins, 1995). For example, "[c]ultural ideologies and institutional policies shape the interactions that take place in health care situations" (Stevens & Hall, 1990, p. 23). Moreover, failure to recognize social factors as influential agents of our well being artificially encapsulates health (Berger, 1983). Basic demographic characteristics (i.e., age, gender, ethnicity, income, sexual orientation) play a large role in determining people's experience of health care. Differences across these demographic markers are evident and warrant consideration.

A common goal of feminist research is to expose relevant aspects of the social structure and concomitant mindset that engender systemic biases that both create and sustain inequality. Despite the substantial gains made as a result of the work of many feminists, health care remains largely under the control of men (Trippet & Bain, 1992). Social structures and systems, including the health care system, remain patriarchal (LeBlanc, 1997).

Feminist practice in health care aims to create and ensure quality health care for all women (Andrist, 1997). Attacks have been launched on aspects of health care systems and practices that by the very nature of their patriarchal structure oppress women (Andrist, 1997). The application of feminist principles as they relate specifically to women's health, is not as simple as increasing the amount of research that includes women, or increasing the funding for research on 'women's' diseases (Duffy, 1985). Duffy maintains that we must remain mindful of the distinction between research "on" women, and research "for" women. The latter, she contends, builds in the potential for social change. Feminist researchers and practitioners have highlighted many problems within the health care system, and continue to actively work toward change.

Health care should be sensitive to the needs of all of its users (Trippet & Bain, 1992). Historically, research done on disease progression and symptomology has focused on patterns exhibited by men (Millner & Widerman, 1994). Quality care is prevented if the fundamentals of diagnosis and treatment are built on a knowledge base that is lopsided. Using men as the norm has resulted in the exclusion of women from research and has stalled the development of tailored prevention initiatives and the appropriate allocation of funding dollars (Adesso, Reddy, & Fleming, 1994).

Judith Rodin and Jeanette Ickovics (1990) in their review of women's health in the United States, report that women continue to be underrepresented in health research. Potential explanations for these authors' contentions are: the beliefs held by

researchers that female hormonal cycles would "contaminate" their study, the need to protect women (and their unborn or future children) from any potential negative consequences of their research, and that the increased cost of including women in research (i.e., because of the increased number of participants required) is unsustainable. It appears as though this pattern of results is duplicated among the gay and lesbian population with health research that does focus on sexual orientation disproportionately representing gay men over lesbian women. For example, Sell and Petrulio (1996) reviewed the public health studies contained in the Medline[2] database for the years 1990 through 1992, and found that of the 152 articles that met their inclusion criteria, 84 focused on gay men and only 24 on lesbian women. This trend, however, may not carry over into the area of unpublished studies. For example, O'Hanlan (1996b) suggests that in terms of information collected, lesbian women fare better representation than do gay men. This, she suggests, is attributable to the fact that "lesbian health activists" have completed seven surveys including over 13,000 participants in total, since 1980[3]. The apparent imbalance in published literature may reflect a limited opportunity to publish lesbian health research (White, 1998).

Feminist research has resulted in many positive changes but has yet to transform the face of health care (Travis, Gressley & Crumpler, 1991). Feminists continue to work to both address and to change gender and other inequalities. For example, some researchers have pointed out that "lesbian health issues are, first, women's health issues" (Rankow, 1995, p. 486), yet women's health research has usually overlooked, or failed to acknowledge lesbian women (Brogan, 1997; Hughes, Haas, & Avery, 1997; Stevens, 1992; Wagner, 1997). It is important to consider differences among women because as Patricia Stevens (1996) suggests, although men generally fare better than women when receiving health care, non-white, poor, uneducated, and lesbian women "bear the biggest brunt" (p. 25) of substandard care.

Rachel Perkins (1995) writes of how, while mental/psychological health service providers are slowly beginning to recognize the importance of acknowledging the influence of gender and race on one's life, the issue of sexual identity has not yet been recognized. A consequence of this lack of acknowledgement is that often "hostile environments are created by default" (Perkins, 1995, p. 19). Physical health care environments, as well as society in general, may also be experienced as hostile by those for whom their realities are denied. Lesbian women share with heterosexual women those factors that are unique to gender (Peterson & Bricker-Jenkins, 1996; Rankow, 1995) but face the additional challenges of societal homophobia and discrimination (White, 1997).

Where are Lesbian Women in Health Research?

Since sexual orientation is not physically observable, and since some women, for a variety of reasons, may be unwilling to disclose this information, lesbian women are essentially a hidden or invisible population (Kunkel & Skokan, 1998; Trippet & Bain, 1992). Lesbian women, especially those who do not match common lesbian stereotypes, are assumed to be heterosexual and can choose either to "pass" (Logan, 1996) or to correct the faulty assumption. Add to this the fact that conditions are often less than optimal for disclosure and that many women may resent having to correct heterosexist assumptions to begin with, the likelihood then that lesbian women will go unnoticed is quite high. It is, therefore, probable that lesbian women have actually participated in studies on women's health but were essentially unidentifiable (Trippet & Bain, 1992). How does this affect the validity of the existing research that has not considered information related to sexual orientation?

Failure to collect information on sexual orientation translates into missed opportunities to assess any unique health issues or concerns of lesbian women (O'Hanlan, 1995). In fact, Katherine O'Hanlan (1995) reports, "no federally funded

population study has ever been stratified by sexual orientation" (p. 107). Moreover, Abby Wilkerson (1994), while discussing the system used by the Centers for Disease Control (CDC) to categorize women as lesbians for disease demographics, states that "it seems unlikely that the government agencies have a stated policy of neglecting lesbian and bisexual women in the (AIDS) epidemic – yet the end result is not altogether different than if there were such a policy" (p. 339). To treat women as a single group is indeed a disservice to, if not a denial of, their individual realities.

When research is conducted on lesbian women, other potential problems surface. For example, one of the problems with health research on lesbian women highlighted by Jocelyn White (1998) is the "assumption of a monolithic population of lesbians" (p. 55). Clearly, this is not the case as lesbians are as diverse a group as are heterosexual women (O'Hanlan, 1995; Perkins, 1995; Rankow, 1995; White, 1998). It is, therefore, important to consider differences between lesbian (within group) women rather than just differences from heterosexual women (between groups) (White, 1998).

Conceptualization of the difference between lesbian and heterosexual women as one strictly of sexual behaviour or gender preference of partners is a mistake (Perkins, 1995). We have all heard the position that lesbian and heterosexual women are the same except for whom they choose to partner with. This argument is usually presented by advocates of sexual diversity as a reason not to discriminate or be prejudiced against lesbian women. However, this "sameness" position denies social realities because the term sameness and its underlying ideology is often "conflated with equality" (Wilkinson & Kitzinger, 1993, p. 9). This view overlooks the often substantial difference in life experience (Messing, Schoenberg, & Stephens, 1984).

Lesbians' experiences in the health care system and their health concerns are often different from those of heterosexual women (Peterson & Bricker-Jenkins, 1996; Robertson, 1992; White, 1997). Rankow and Tessaro (1998) suggest that lesbian

women may be an "underserved" group who have "unique barriers" to health care. In addition to the gender discrimination experienced by women in health care settings, lesbian women often experience additional stigmatization as a result of their sexual orientation should it become known (Platzer, 1993; Rankow, 1995; Trippet & Bain, 1992). In fact, Stevens and Hall (1991) suggest that when seeking health care, lesbian women are often in "vulnerable positions" (p. 291).

For example, lack of awareness or knowledge of the sexual orientation of a patient, in addition to the assumption of heterosexuality, can cause HCPs to address irrelevant or ignore relevant aspects of their patients concerns, experiences, and their lives (Cochran & Mays, 1988; Rankow, 1995). Moreover, if a lesbian patient decides to disclose her sexual orientation to her HCP, it is important for the practitioner to understand the social implications on the entirety of her life (Mathieson, 1998). Mathieson reports that almost all (94%) of the 98 lesbian and bisexual women that she interviewed highlighted the necessity of having a "gay positive" HCP. Gay positive, she suggests, "means that a provider is sensitive to the realities of being lesbian or bisexual in a fundamentally heterosexist world" (Mathieson, 1998, p. 1637). The context within which lesbian women live varies from that of heterosexual women on many levels ranging from fear of job loss, marginalization, invisibility (Perkins, 1995), stigmatization (Stevens & Hall, 1988), and fear for loss of housing, family and children (O'Toole, 1996). It is not unreasonable to expect that these factors may have health consequences.

Platzer (1993) suggests that the paucity of research on lesbian health follows directly from the fact that lesbian women are a hidden population. Stevens (1992) reviewed two decades of research on lesbian women and health care. She found a total of 28 studies, all of which were conducted in the United States. Nine (8 published in peer-reviewed journals) of the studies dealt with attitudes of HCPs toward lesbian women. The remaining 19 (15 published in peer-reviewed journals) involved the

experiences of lesbian women in the health care arena. Although health research that has either included or focused on lesbian women has recently been increasing, much remains unknown (Hughes et al., 1997; Kunkel & Skokan, 1998). Much of the early research on lesbian women and health care focused on how lesbian women felt about the health care they received and the providers that they received it from (Trippet & Bain, 1990). Few studies have considered factors other than barriers, that may influence lesbian women's utilization of health care services (Kunkel & Skokan, 1998).

O'Hanlan (1995) suggests that quality research must inform the medical care of lesbian women. There is, she suggests, an absolute need to become aware of the "unique medical demographic profile" (p. 101) of those in the gay and lesbian communities. O'Hanlan maintains that "with greater understanding of who lesbians are and the psychological effects of societal disdain for them, obstetricians and gynecologists can maintain the highest standard of medical care-giving to all their patients, including the lesbian patients" (p. 101). Clearly, this applies to all primary care providers as well.

Underutilization of Health Services

Much of the literature on lesbian health suggests that many lesbian women either delay or do not seek health care (Denenberg, 1995; Kunkel & Skokan, 1998; Mann, 1996; Mathieson, 1998; Robertson, 1992; Stevens, 1992; Stevens, 1996; Trippet & Bain, 1990; Trippet & Bain, 1992; Wagner, 1997; White & Dull, 1997). Among the reported reasons that lesbians cited for avoiding or delaying health care are: institutionalized heterosexism and homophobia (Peterson & Bricker-Jenkins, 1996); heterosexist assumptions by HCPs; insensitive care; fear that they will be discriminated against; financial reasons; a faulty belief that lesbians do not need Papanicolaou (Pap) smears (Kunkel & Skokan, 1998); misinformation about health care needs (Mathieson, 1998; Ott & Eilers, 1997; Peterson & Bricker-Jenkins, 1996); a lack of motivation because there is

no need for birth control (Ott & Eilers, 1997); and prior negative experiences within the health care system as a result of their sexual orientation (Mathieson, 1998).

Ott and Eilers (1997) suggest that this apparent underutilization of health services by lesbian women may be a result of the stigmatization, oppression, and hostility that they face in these arenas. Past negative experiences in their health care interactions often create situations where lesbian women become "reluctant" to seek care (Brogan, 1997; Rankow & Tessaro, 1998; Stevens, 1992). Stevens (1996) reports that in her feminist narrative study of health care experiences of an ethnically diverse group of lesbian women in San Francisco, 78 (23%) of the 332 health care stories described positive experiences and 254 (77%) described negative experiences[4]. The women in this sample told stories involving being "bullied", "bruised", receiving "rough" physical exams, and being given birth control pills with a high level of estrogen because the doctor felt that they did not "have a very 'feminine presentation'" (p. 35). Stevens, summarizing the content of the stories, concludes that when lesbian women seek health care "they not only risk verbal intrusion on their dignity, denigration of their intellect, and dismissal of their concerns, but also risk loss of control over bodily appearance and reproductive functioning, violation of bodily safety, and sexualization" (p. 37). Under these circumstances reluctance to seek health care is certainly understandable.

Insensitivity or insufficient attention to their specific treatment needs may also cause some lesbian women to avoid health care environments (White & Dull, 1998). Interactions with HCPs that are characterized by a lack of opportunity for effective communication, as well as by discomfort with anticipation of disclosure to HCPs may also result in avoidance or delay of care seeking (Messing et al., 1984; White & Dull, 1998). This lack of sensitivity to and awareness of lesbian issues is a problem expressed by many lesbian women (Trippet & Bain, 1992; Matthews, 1998) and may negatively

affect health seeking behaviour generally, and preventive or routine care specifically (White & Dull, 1998).

Regular preventive care facilitates early detection, a crucial factor in disease control (Kunkel & Skokan, 1998), and is critically important for "improving the overall health of our population" (Pearse, 1994, p. 42). Routine care visits are ideally a venue where health information is exchanged. Health care providers should dispense valuable health, preventive care, self-care, and nutritional information to patients during routine or preventive health care visits, as well as perform screening and look for early warning signs of various disease processes (i.e., heart disease, cancer, etc.; O'Hanlan, 1996b). This proactive approach to health care is vital to maintaining physical well-being.

Preventive health care by someone familiar with one's unique risk factors is essential. A report by the Council on Scientific Affairs for the American Medical Association (AMA) states that the distribution of certain cancer risk factors may have different patterns in lesbian populations than they do in heterosexual female populations (AMA, 1996). For example, nulliparity (never having given birth to a child), is more common in women with breast cancer, and has also been identified as a potential risk factor for ovarian and endometrial cancer whereas the use of birth control pills may offer some protection against endometrial cancer. Lesbian women are more likely than heterosexual women both to be nulliparous and not to have taken oral contraceptives. Clearly, early detection through clinical breast exams and mammography are especially important for women who have these risk factors (Ott & Eilers, 1997). Knowledge of a patient's sexual behaviour history, and not just their current self-identification is also important information for the HCP to have (Smith, Heaton, & Seiver, 1989). Disease risk patterns and consequently, screening recommendations, vary substantially with the presence of past heterosexual behaviour.

Many women maintain regular contact with the health care system by adhering to the practice of receiving regular Pap smears (Rankow, 1995). Rankow (1995) suggests that this is often the "access point to preventive health care" (p.487). Studies have found that for lesbian women the length of time between Pap smears is significantly longer than that for heterosexual women (Rankow, 1995; Wagner, 1997) or in some cases lesbians avoid them completely (White, 1997). Rankow and Tessaro (1998) report that approximately 25% of their sample of 512 lesbian, bisexual, and women who have sex with women, had not had a Pap smear in the three years prior to the survey. Moreover, almost 8% of the women reported having never had a Pap smear at all. This finding matches that found by Johnson, Guenther, Laube, and Keettel (1981) where 8% of their sample of 117 women (100 of which were lesbians, 15 bisexual, and 2 not identified) reported never having received a Pap smear. One third of a recent Canadian sample of lesbian and bisexual women reported that they did not seek preventive or routine care or did not go for Pap smears or clinical breast examinations (Mathieson, 1998). Johnson et al., (1981) also found that while 46% of their sample reported that they had physical examinations yearly, the majority of the women (53%) only sought episodic care.

Research also suggests that some lesbian women not only avoid or delay seeking preventive care, but also episodic care. Mathieson (1998) suggests that half of the women that she interviewed reported not seeking health care "at least once" because of their sexual orientation. Other studies have also found evidence of delay or avoidance of seeking episodic care. For example, Kunkel and Skokan (1998) found that 67% of their sample reported "that they had not gone to a doctor when they needed to go" (p.11). Trippet and Bain (1992) found that 24.7% of their lesbian sample failed to seek needed health care. White and Dull (1997) report that in their sample 23% of the women reported waiting until a problem worsens to seek care (the delay ranges from several days or weeks) or not seeking care at all. It is interesting to note that in this

sample 90% of the women reported being out to "at least one" of their HCPs and were recruited from attendees of a lesbian health care conference, or from members of the Lesbian Community Project where lesbian health issues are included in the group philosophy.

Given that early detection is often the determining factor in the successful treatment of many diseases (Kunkel & Skokan, 1998) delaying or avoiding care-seeking is clearly a problem. Delayed diagnosis as a result of not receiving regular care, or not seeking care until a disease or illness has progressed often results in more invasive treatment, and increased mortality risk (Peterson & Bricker-Jenkins, 1996), as well as potentially affecting "both quality of life and survival probability" (O'Hanlan, 1996b, p. 411). It is important to try to discover what factors affect risk and resilience in lesbian women and to use this information to create conditions that are the most conducive to optimal utilization of health services.

Heterosexism and Homophobia: The Terminology

Recent literature has focused on distinctions between the current usage of the terms homophobia and heterosexism. Homophobia is defined in the dictionary as "irrational fear or hatred of homosexuals or homosexuality" (Webster's New World College Dictionary, 1996, p. 647). The definition of homophobia as described by Weinberg (1972) is "the dread of being in close quarters with homosexuals" (Weinberg, 1972, as cited in Logan, 1996, p.32).

Logan (1996) suggests that the term homophobia excuses those who discriminate or oppress lesbian women and gay men as their behaviours are interpreted, at least implicitly, as attributable to "inescapable fear" (p. 32). Fear does not cause discrimination; prejudice and hostility does (Logan, 1996). It is the notion of the inescapability, the irrationality, or the lack of personal accountability, grounded in some sort of psychic fear that has often been at the crux of the argument of those who oppose

this term. Celia Kitzinger (1996) also argues against the usage of this term but from an entirely different perspective. She suggests that it is the irrationality part in the definition of the term phobia, rather than the fear part, that is in fact erroneous. At least with respect to the social response to lesbian women, fear is not at all irrational, but is in fact a very rational response to the potential threat of women shifting the focus of their lives from men toward other women, thereby shaking the very foundation of a society that is built and maintained on a patriarchal structure (Kitzinger, 1996).

Logan (1996) reviews other terms that have been suggested to replace, or more accurately represent, society's as well as some individuals' attitudes toward lesbian women and gay men. The term, she suggests, must shift the blame away from irrational fear and place it at the feet of discrimination. For example, homonegativism, homoprejudice, and heterosexism have been suggested as substitutes for the term homophobia (Logan, 1996). Criticisms of the term homophobia have also come from those who endorse discrimination against anyone who is not heterosexual. Authors of a comment on an article by Rankow (1995) (who used the terms homophobic and homophobia to describe the negative experiences of some lesbian women in the health care arena), also indicated dissatisfaction with the term. Fletcher and Payne (1995), for example, submit that "practically speaking, homophobic is a pejorative spat at anyone who dares to disagree with homosexual activists" (p. 227). They suggest that the term "homomorbid" is more precise because "homosexual practices causes us a sensation of illness" (p. 227).

Some researchers have suggested the term heterosexism should replace the term homophobia (Logan, 1996) while others have described heterosexism as a "more subtle form of discrimination" (Peterson & Bricker-Jenkins, 1996, p.39) than is homophobia. Peterson and Bricker-Jenkins (1996) suggest that the term heterosexism most often refers to the tendency to assume that all people are heterosexual. Others

though, see the term as more encompassing and independent. For example Spaulding (1993) offers an understanding of heterosexism as "a significant and systematic social and cultural ethos that structures our social arrangements and shapes our views of lesbianism. Heterosexism permeates our cultural institutions and the belief systems that legitimate their structures" (p. 232).

While not denying the necessity to find a term that places the blame of anti-homosexual action wholly and unequivocally on the shoulders of those that partake in it, for the purpose of this paper I will use the terminology that has been used in the majority of the research reviewed here. Homophobia will be used to refer to anti-lesbian behaviour or sentiment either covert or overt. Heterosexism will be used when dealing primarily with assumptions of heterosexuality.

Heterosexism in Health Care

Heterosexuality is the default sexuality option of most people and of most institutions. The result of heterosexism is that lesbian women are effectively marginalized. Marginalization as defined by LeBlanc (1997) is "the process through which persons are peripheralized on the basis of their identities, associations, experiences and environments" (p. 260).

White (1998) suggests that "institutionalized heterosexism" results in many lesbian women avoiding or failing to seek health care. The assumption of heterosexuality prevents effective communication (Johnson & Palermo, 1984; Stevens, 1992) and thrives in both the mental health (Perkins, 1995) and the physical health (Ott & Eilers, 1997; Rankow, 1995; Stevens, 1992) arenas. Ignoring deviations from heterosexuality "effectively silences the lesbian" (Perkins, 1995, p. 19).

Heterosexist bias is often so deeply engrained that many people fail to notice its pervasiveness (Lucas, 1992; Rankow, 1995). Questions asked (or not asked) by many health care practitioners clearly illustrates this point (Rankow, 1995; White, 1997). For

example, if asked about the type of birth control that you use, the assumption that sexual activity may result in pregnancy is clear. Lesbian women need not worry about birth control. How then are they to respond to this question? Some women may not feel comfortable giving a sexual history to begin with. Imagine then, how this assumption has the potential to increase their discomfort. Creating a situation that requires women to break the flow of questioning by placing them in a situation where they must either offer information that corrects the practitioner's faulty or inappropriate assumptions (i.e., "my partner is a woman not a man") and thereby expose themselves (White, 1997) or allow the practitioner to continue their faulty assumption by not offering the relevant information (Johnson & Palermo, 1984; White, 1997). From the outset then, a barrier is wedged between the patient and the HCP (White, 1997) and the possibility of effective communication may become blocked (Johnson et al., 1981). In fact, White and Dull (1998) report that many of the respondents in their survey claimed that it was a situation similar to the one just described that prompted (or forced) their coming out to their HCP. Stevens and Hall (1988) suggest that almost all of the women they interviewed reported "that there was no routine comfortable way to let health care providers know that their heterosexual assumptions were not applicable to them as lesbians" (p. 72).

If HCPs do not ask, and if lesbian women do not tell, providers may not even be aware that they are treating lesbian women (Brogan, 1997; Kunkel & Skokan, 1998; Stevens, 1992) and the perpetuation of ignorance allows for the continued offering of irrelevant or even inappropriate advice and recommendations at the expense of relevant information. Lesbian women have the right to expect not to be inundated with irrelevant information, as well as to be provided with appropriate information (Peterson & Bricker-Jenkins, 1996). In fact, many of the women in Johnson and Palermo's (1984) study felt that their gynecologists were not even knowledgeable about "lesbian health care issues" (p. 729). If HCPs are not informed about issues specific to lesbian health then the needs

of this population will go unmet (Platzer, 1993; Rankow, 1995; Stevens, 1992). Furthermore, if, as suggested by Carroll, Goldstein, Lo, and Mayer (1997), HCPs are not even aware of their patients' sexual orientation or sexual behaviour, the quality and appropriateness of the care that they provide will be compromised.

Accurate knowledge of a patients' sexual orientation guides many aspects of the health care interaction, from assessing risk factors to informing intervention choices (Brogan, 1997; Matthews, 1998; Robertson, 1992). For example, the belief that lesbian women are not at risk for sexually transmitted diseases (STDs) or do not need Pap smears is often held both by lesbian women (Rankow, 1995; Wagner, 1997) as well as by many HCPs (Carroll et al., 1997; Mathieson, 1998; O'Hanlan, 1996a). Additionally, HCPs often overlook the possibility of past sexual experience with men (voluntary or involuntary) which also influences health screening decisions (Edwards & Thin, 1990). Failure to, or a delay in seeking health care as well as receiving compromised care may lead to increased morbidity and mortality (O'Hanlan, 1996b; Rankow, 1995).

Homophobia in Health Care

All people should be concerned with societal homophobia. O'Hanlan (1995) suggests that "the process of homophobia – the socialization of heterosexuals against homosexuals and concomitant conditioning of gays and lesbians against themselves – must be recognized by health care providers as a legitimate and potent health hazard" (p. 123). Homophobia is a primary concern for lesbian women (Trippet & Bain, 1993). In fact, Trippet and Bain (1993) suggest that it plays a substantial role in the health-seeking behaviour of many lesbian women. Some of the concerns expressed by the women in the White and Dull (1998) sample were the fear of being judged, embarrassment, and expectations of homophobic responses. Trippet and Bain (1992) suggest that the decision of many of the women in their sample to seek non-traditional (rather than traditional) care was rooted in the fear of, or "actual experience of discrimination from

health providers" (p. 151). Several studies have in fact shown that negative attitudes toward lesbian women and gay men are widespread within the medical community (O'Hanlan, 1995).

Being a lesbian is still viewed negatively by many health care providers (Stevens & Hall, 1991). Some providers see lesbianism "as a pathological condition, make attributions of immorality, perversion, ...are uncomfortable providing care for lesbian clients, and regularly refuse to service women who are lesbian" (Stevens & Hall, 1991, p. 291). A survey of the members of the American Association of Physicians for Human Rights conducted in 1994, found that 52% of the 711 respondents reported being aware of incidents where lesbian or gay patients had been denied care or had received "suboptimal" care (Schatz & O'Hanlan, 1994 as cited in O'Hanlan, 1995, p. 106). Summarizing the findings of her review of two decades of research on lesbian women and health care, Stevens (1992) concludes that prejudice not only exists but is widespread and often blatant. Clearly then, lesbian women fear discrimination for a good reason.

Internalized Homophobia: The Effect on Health Care

O'Hanlan (1995) outlines the distinction between homophobia working externally versus internally. "Internal homophobia represents learned biases that all individuals incorporate [internalize] into their belief systems as they mature in a society biased against homosexuals. External homophobia is the overtly observed or experienced expression of those biases" (O'Hanlan, 1995, p. 105). Socially sanctioned negative reactions or prejudice against lesbian women may be directed inward by some women resulting in them feeling inferior (Logan, 1996). Stevens and Hall (1988) report that the lesbian women that they interviewed believed that internalizing society's negative attitudes toward lesbians was a health risk for many lesbian women. Although the relationship between IH and health care utilization has not been directly tested in the

published literature, it seems plausible that a relationship does exist. In fact, the need to investigate the effect of IH on health and on the underutilization of health services has recently been included among a series of lesbian health research priorities outlined by the APA (Patterson, 1998).

The internalization[5] of society's attitudes toward lesbian women and gay men may result in compromises to self-esteem and lead to increased feelings of isolation (Rankow, 1995). Participation in lesbian communities and activities may help to offset the internalization of negative attitudes (Rankow, 1995). Sophie (1987) discusses internalized homophobia and lesbian identity and discusses ways to help women move from a negative sense of self or self-identity to a more positive and self affirming identity by helping to eliminate the internalized homophobia that the woman is experiencing. Fundamental to this process, she suggests, is a reinterpretation of what being a lesbian means. Sophie suggests that one way to alter this perception is to challenge the stereotypes of lesbian women. A feminist perspective or ideological stance, in addition to exposure to other lesbian women who can act as positive role models, facilitates this transformation. Downey and Friedman (1995) also suggest that with integration into the lesbian communities, feelings of internalized homophobia generally tend to dissipate.

One must be careful however, not to overemphasize the personal cause of internalized homophobia because in so doing we "risk that consideration of negative social forces will be neglected" (Healy, 1993, p. 262). It is important to recognize that without societal and institutional homophobia and heterosexism, internalized homophobia would not be an issue.

Disclosure of Orientation

"[B]eing a lesbian profoundly affects the whole of a woman's life" (Perkins, 1995, p. 19). Disclosure of sexual orientation is often a major event for lesbian women. Moreover, falling short of wearing a sign on your forehead, this is something that must

be done over, and over again (Healy, 1993; Tiemann, Kennedy, & Haga, 1998). This "unending process" (Healy, 1993) has no parallel in the lives of heterosexual women (Bradford, Ryan, & Rothblum, 1994).

Heterosexism "both facilitates passing and creates barriers to self-disclosure" (Healy, 1993, p. 249). Healy describes a "paradox of self-preservation" whereby lesbian women may be out in several areas of their lives but in a given situation they may have to weigh the cost of coming out (thereby remaining true to oneself) against the potential risk of (real or perceived) harm should ones sexual orientation become known as deviating from the norm. Some women may perceive the health care arena as one such situation. Self-negation, she suggests, may be seen as essential to "secure...safety" (p. 260). Although self-negation can be considered an act of self-protective behaviour nondisclosure can result in women feeling invisible or estranged "from the health care process" (Stevens & Hall, 1990, p.25). This cost benefit analysis is an ongoing process for many lesbian women that often informs their decisions to disclose (Mathieson, 1998).

Disclosure of sexual orientation in health care settings is not a given. Many lesbian women are reluctant to, or avoid, coming out to their HCPs (Cochran & Mays, 1988; Wagner, 1997), are afraid to come out or are afraid of the potential consequences of disclosure (Johnson & Palermo, 1984; Platzer, 1993; White, 1998), believe their health care would be adversely affected by disclosure (Lehmann, Lehmann, & Kelly, 1998; Smith, Johnson, & Guenther, 1985), and experience disclosure as a stressful event (Matthews, 1998; Stevens & Hall, 1990).

Matthews (1998) found that many factors influenced a lesbian woman's decision to tell (or not to tell) her HCP about her sexual orientation. She suggests that how "out" a woman is in other aspects of her life, her feelings about the health care setting, her belief that she can choose freely from among all available HCPs, her access to financial resources, and the type of problem for which she is seeking care all play a role in

determining whether or not a woman will disclose her sexual orientation. For example, Matthews (1998) quotes one woman as saying "I wouldn't have said that I was a lesbian if it wasn't that I was having female problems" (p. 196). Also, if finances are limited, HCP choice is restricted, and a woman is unable to access other resources, a lot may be riding on keeping her health care experiences bearable (Matthews, 1998). Stevens (1992) accurately describes this process as a balancing act.

Robertson (1992) interviewed 10 lesbian women about their health care experiences. While discussing disclosure of their sexual orientation to their HCPs the following quotes illustrate how widely responses can vary. One respondent said "You hope they don't ask, you know, like what's going on in your sex life, because you're going to have to answer or lie" (p. 159). Another respondent described how she reacted to a heterosexist comment "When I went into her office she said 'you're sexually active and not using birth control?' and I said 'yes, I live with a woman'" (p. 159). A third respondent told of how she reacts to a biased questionnaire "I just write down that I am a lesbian and that they are very heterosexist questions and that they need to change their questionnaire" (p. 159).

In their study of Black lesbian and bisexual women, Cochran and Mays (1988) found that 45% of the lesbians reported that their "physician does not know" of their sexual orientation, and an additional 11% reported that their "physician may suspect." Only 33% reported that their physician knows and that "the topic had been discussed." Kunkel and Skokan (1998) report that 54% of their sample of lesbian women had disclosed their orientation to their HCP, but only 15% were actually asked about sexual orientation by their providers. Overall, estimates of the percentage of lesbian women that disclose their sexual orientation to HCPs range from a low of 18% reported by Johnson and Palermo (1984) to a high of 90% of the sample reported by White and Dull (1998). This finding of a 90% disclosure rate was extremely inconsistent with the majority of

findings in other research. In fact, only three percent of the sample reported not being out to any of their providers. White and Dull (1998) recognize that this may be a result of the fact that this sample was recruited through a community organization where a monthly lesbian health newsletter had been being circulated to members for several years.

White and Dull (1998) found that the women who had disclosed their sexual orientation to their HCPs "were more likely to seek preventive care, more likely to have Pap smears, and were more comfortable in discussing difficult issues" (p. 107). Martinson, Fisher, & DeLapp, (1996) also found that in their sample of 411 lesbian women in Alaska, those women who had disclosed to their HCPs were more likely than those who had not disclosed, to have received a physical exam in the preceding five year period. Disclosure, they suggest, appears to have a positive effect on utilization of health services.

Tiemann, Kennedy and Haga (1998) report that decisions to disclose orientation to a HCP is often preceded by "screening" -- a protective strategy used by some where they gather information about a provider in order to make safety judgements about disclosure. Lesbian women may look for clues in behaviour and language of HCPs that indicates how accepting or unaccepting they would be toward disclosure (Brogan, 1997; Stevens, 1992). The feeling of being in a "safe" environment necessarily underlies willingness to disclose (Mathieson, 1998). This avenue is, however, blocked if one is seeking emergency care and therefore does not have an opportunity to prescreen potential HCPs (Stevens & Hall, 1990). Nearly all (96%) of the women in Stevens and Hall's (1990) study were able to "anticipate" circumstances that knowledge of their sexual orientation by HCPs could result in personal harm. From their review of research from 1970 to 1995, White and Dull (1997) suggest that while the majority of lesbian women do not come out to their doctors, of those that do, anywhere from one-fifth to

three-quarters of the women surveyed reported experiencing negative consequences of disclosure or negative reactions from their HCP.

Past Negative Experiences

Negative reactions toward lesbian women are widespread in our culture (Logan, 1996). Several studies report that many lesbian women have experienced negative reactions after disclosure of their orientation to their HCPs. Among the negative experiences reported were: women feared for their safety, experienced hostility, rejection, condemnation and mistreatment, and felt pathologized, and embarrassed (Stevens, 1992); referrals for psychiatric intervention, "rough" internal exams, and being refused care (Mathieson, 1998); women described feeling ostracized, being responded to with invasive questioning, shock, unfriendliness, pity and condescension (Stevens & Hall, 1990); the lack of recognition or respect for same-sex partners as "next-of-kin" or family (Peterson & Bricker-Jenkins, 1996; Platzer, 1993) which may result in lack of access to information and being denied visitation when restrictions exist (Jones, 1988; Platzer, 1993), a lack of support for the patient-defined family (Peterson & Bricker-Jenkins, 1996), and prevention of loved ones from participation in decision-making (Jones, 1988). A particularly poignant example of this type of exclusionary tactic is found in Matthews (1998). Matthews (1998) relays one cancer patient's experiences of the treatment of her partner, she quotes "for example, after my last surgery the doctor didn't even speak to her. She was just left there waiting" (p. 197). Pathologizing is evident in Tiemann, Kennedy and Haga's (1998) study of rural lesbian women where one woman reports that when asked during her initial visit to a neurologist why she was not on birth control, her reply that she was a lesbian prompted the following response "he immediately decided I should take the MMPI [!]" (p.67).

Matthews (1998) interviewed lesbian women who were members of a cancer support group conducted by the Lesbian Community Cancer Project (LCCP). Many of

these women not only felt that HCPs were often not aware of and/or were insensitive to, the health concerns of lesbian women, but also "were almost unanimous in their perceptions of the 'medical establishment' as hostile toward lesbians" (Matthews, 1998, p. 196).

Research has revealed widespread reports of both the actual experience, as well as the expectation, of negative reactions to disclosure. For example, Stevens and Hall (1988) report that 72% of the women they interviewed were able to recollect negative experiences in their health care interactions. In fact, they reported that 36% of the women spoke of experiences where they had either been unable to follow the visit through to completion, or had been unwilling to return for further care as a result of negative "events following disclosure" (Stevens & Hall, 1988, p. 72). Studies have also shown that women often felt that their care would be negatively affected if they were to disclose their orientation to their HCPs. Through the years percentages have ranged from 31% in a recent study by Lehmann et al., (1998), to 40% in an early study by Johnson et al., (1981). Notably little evidence of progress was observed in the 17 year span.

Negative experiences in traditional health care settings may turn many lesbians away from traditional Western medicine and toward non-traditional or alternative care (Peterson & Bricker-Jenkins, 1996; Trippet & Bain, 1992). Moreover, it is not always necessary to experience the negative situations directly since second hand knowledge about the bad encounters of others may still result in a decision not to disclose (Denenberg, 1995; O'Toole, 1996; Stevens, 1992) or in avoidance of traditional health care.

Alternative Care

In February, 1999 the Canadian Women's Health Network (CWHN) website included an article that reported on the annual meeting of the Society of Obstetricians

and Gynecologists of Canada (SOGC) held in June of 1998 (http://www.cwhn.ca). It was suggested that in addition to delaying much needed health care, lesbian women may also "forego using traditional sources of health care in favour of natural or alternative care" (p. 1). This, they suggest, is a result of past negative experiences with the traditional health care as well as of fearing the consequences associated with disclosure in traditional settings.

Many lesbian women do feel as though their needs are not being met by the traditional health care system (Peterson & Bricker-Jenkins, 1996; Trippet & Bain, 1992) and often do "respond proactively to the barriers that they face in the conventional medical system by renegotiating and redefining health care" (Peterson & Bricker-Jenkins, 1996, p. 41). In their study, Trippet and Bain (1992) found that several reasons were cited for turning away from traditional care. For example, the failure of traditional health care to provide low-cost, natural, alternative and holistic care, as well as preventive care and education; a lack of respect and lack of communication; and the lack of availability of health care clinics that are run by women.

Stevens and Hall (1988) conducted interviews with 25 lesbian women in Iowa and reported that the women in their sample tended to have a holistic perspective of health that incorporated the importance of considering the 'health strengths' among lesbians as well as their concerns. Health, they suggest, was seen as tripartite, including not only the physical but also the emotional and social aspects. These women tended to view alternative health care (i.e., homeopathy, massage, chiropractic, and acupuncture) favourably, and supported attempts to circumvent traditional Western care.

White and Dull (1998) also found that, at least for lesbian women in the Western United States, alternative HCPs are often preferred over traditional HCPs. In their sample, 31% of the women reported using alternative providers for primary health care needs. Alternative providers were judged to be 'easier to communicate with' and the

women reported greater ease in talking about sexual orientation and 'difficult issues' than reported with traditional doctors and also found them to be more understanding of their needs (White & Dull. 1998). Interestingly, no difference was found between traditional and non-traditional HCPs on the rate of disclosure or the experience of the initial disclosure conversation. Other studies have also reported high rates of use of alternative care providers among lesbian women (Bradford, Ryan, & Rothblum, 1994; Denenberg, 1995; Johnson & Palermo, 1984).

Matthews (1998) found that the lesbian women in her sample "who were more strongly tied to the lesbian feminist communities placed a high value on self-advocacy" (p. 199). These women often chose to supplement their cancer treatment with complementary or alternative methods of health care. In a comparison study of lesbian and heterosexual women Buenting (1992) concluded that lesbian women appeared to have "a more holistic health orientation" (p. 170) than did the heterosexual women. Lesbian women, she suggests, reported adhering to alternative diets and practicing meditation and relaxation techniques more often than heterosexual women. Heterosexual women, on the other hand, reported receiving more regular Pap smears.

A recent study on why people use alternative methods of health care tested three proposed explanatory theories (Astin, 1998). Astin summarizes the recent theoretical positions and concludes that the use of alternative care may be a consequence of one of the following: dissatisfaction with traditional health care; the desire to have more personal control over one's health care; and alignment with certain philosophical beliefs. Among the values that are central to the philosophical perspective that aligns itself with alternative medicine are a commitment to feminism, self-actualization, and self-expression (Astin, 1998). Astin tested these three positions on a national sample drawn randomly from among a group of people who had agreed to be a part of a database that would be used to participate in various surveys (n = 1035). He found that for the

participants who used alternative medicine along with traditional medicine (i.e., as complementary medicine), only alignment with ones' philosophy, and not dissatisfaction with traditional care or the desire for more personal control significantly predicted use of alternative care. However, for those who reported using alternative care, rather than traditional care, dissatisfaction with and distrust of traditional providers, along with the desire to have more personal control over their health care all significantly predicted use of alternative health care.

Given these results, one may expect that feminist identified women may use alternative or complementary care in conjunction with traditional care because it is part of a belief system or a philosophical stance that aligns more closely with feminist, than with non-feminist ideology. On the other hand, if internalized homophobia leads one to avoid traditional health care and use alternative medicine instead, utilization rates of alternative care would still be up, but for an entirely different reason than is the case for feminist women.

Why a Lesbian-Only Sample?

The primary goal of this study was to examine factors which may foster or impede optimal utilization of health services by lesbian women. To this end, the sample was limited to this target population. What feeds susceptibility and what promotes resilience to a commonly hostile environment? One cannot expect to find these answers by comparing groups of women who essentially live in different worlds. The assumption of heterosexuality rings true for one group and untrue for the other. Heterosexuality does not generally provoke moral judgements or societal hostility. The only way to access information on differential risk and resilience is to focus on differences among lesbian women, not on differences from heterosexual women. Therefore, the central, rather than the peripheral, focus of this study was to explore within group differences in search of predictors of risk and resilience in lesbian women.

Researchers of diverse or minority populations have warned against the tendency of researchers to allow between group differences to overshadow within group variance. Kato and Mann (1996) for example, caution that "the merits of between-group comparisons should be tempered by an appreciation of the substantial heterogeniety and behavioral variability that characterize these groups" (p. xii). The information gleaned from studying single groups can be used to enhance the effectiveness of intervention programs by addressing group needs more specifically (Kato & Mann, 1996). By concentrating on within group differences we are also better able to tease out which factors affect risk and resilience for a given population (Kato & Mann, 1996). It is important to gain an understanding of which factors may foster and which factors may impede optimal utilization of health services for lesbian women. And as Stevens (1992) points out, establishing "a coherent body of knowledge about lesbian health care, ... can facilitate the provision of accessible, comprehensive, and empathetic care" (p. 92). Conversely, failure to consider individual diversity hinders both effective treatment and the development of adequate knowledge and understanding.

It is important to remain mindful of the diversity in women, and in all people. For researchers conscious of this diversity in human existence, it is a challenge to disentangle the factors that play important roles for particular groups (Kato & Mann, 1996). Focus on diverse groups will allow the system to fine tune itself to respond appropriately, and to tailor promotion, prevention, intervention, and treatment efforts to maximize their effectiveness for the target population (Kato & Mann, 1996). The benefit of providing specialized heath care does not limit itself to the recipient of such care. Kato and Mann (1996) suggest that "customized interventions that are sensitive to issues of age, gender and orientation, and ethnicity promote better health for all people" (Kato & Mann, 1996, p. xv). Lesbian women are both underrepresented and homogenized in

women's health research. Restricting this study to lesbian women addressed both of these problems.

Sampling Issues

Lesbian health research is fraught with difficulty (White, 1998). White (1998) outlines four areas where challenges present themselves. First, she suggests, institutionalized heterosexism essentially blinds the medical community to the existence of lesbian women. And should lesbians become visible, they are often conceptualized as a homogenous group of women where natural diversity is not acknowledged. Funding for research on lesbian health also presents a challenge because funding opportunities for this type of research are very limited (White, 1998). Finally, White suggests, should all of these preliminary barriers be overcome, one still may be faced with a severely restricted opportunity to publish the research. This, White suggests may act as a 'disincentive' to conduct lesbian health research.

While institutionalized heterosexism veils the existence of lesbian women to the medical community, societal heterosexism and homophobia creates barriers to access making it difficult from a practical and a methodological perspective. Any researcher who wants to study an invisible population is familiar with the problems of population access. Lesbian women are a hidden population, and, therefore, most (if not all) research sampling has been nonrandom (Bradford, Honnold, & Ryan, 1997; Trippet & Bain, 1993). Methodological problems go hand-in-hand with societal homophobia (Rankow & Tessaro, 1998; Trippet & Bain, 1992). Lesbian women who participate in research studies are at a very minimum comfortable enough with themselves and their sexual orientation to disclose it under these circumstances. To date, no one has found a way to circumvent these problems. By casting the sampling net widely, utilizing a variety of recruitment techniques, and by providing survey acquisition alternatives that varied in

the degree of face-to-face contact required, this study attempted to facilitate access for a broader range of women.

Economic Factors As Barriers to Health Care

Studies conducted in the United States, where access to health care is dependent on medical insurance, often find that many lesbian women reported not seeking care due to financial limitations. Price, Easton, Telljohann, and Wallace (1996), suggest that preventive health care is especially susceptible to financial concerns. In countries where access to health care is not guaranteed the inability of many women to include their female partners on their medical insurance results in financial difficulties. If one has to weigh not only whether they should seek health care, but whether they can afford to seek health care, the utilization equation changes. One way to exclude the potential confound of lack finances (or the availability of health insurance) on utilization is to conduct a study in a country with a universal health care system. Canada is one such country.

The Canadian health system "provides access to universal, comprehensive coverage for medically necessary hospital, in-patient and out-patient physician services" (Health Canada: http://www.hc-sc.gc.ca, p. 1). All Canadian citizens, at least in principle, have access to a "high quality universal health care system" (Paltiel, 1997, p. 47) that is transportable across provincial lines (Paltiel, 1997). Therefore, research on Canadian lesbian women should eliminate the financial aspect of underutilization of health care services. There is clearly a need for more research which focuses on Canadian women, both because of the different structure of the health care system in Canada and because Canadian research in this area is severely limited (Mathieson, 1998). In a recent study that did focus on Canadian women the author concludes that "lesbian ... women are receiving less than optimal health care in a Canadian system that prides itself on equal access" (Mathieson, 1998, p. 1639). It appears as though finances are not the only

factor affecting the health care of lesbian women. Because the health care system in Canada is not comparable to the United States this study will restrict participants to women who currently reside in Canada.

Hypotheses

The majority of research on lesbian health has focused either on HCP's attitudes toward lesbian women, or on the women's experiences in the health care arenas (Peterson & Bricker-Jenkins, 1996). Stevens and Hall (1991) suggest that not only is it important to look at issues of lesbian women's experiences with and access to health care, but it is also important to try to isolate or determine which factors "facilitate their utilization of health care systems" (p. 291). This study attempted to answer this call by investigating some potential factors that may influence utilization rates but that have not been included in previous research.

One of the goals of this research was to investigate the relationship between lesbian women's level of internalized homophobia and the extent to which they utilize the health care system. It has been suggested that the incorporation of society's negative attitudes toward lesbian women into one's sense of self may pose health risks for some women. Although appearing intuitively reasonable this contention has not been empirically tested. Using the Internalized Homophobia Scale for Lesbians (IHSL) developed by Szymanski and Chung (1998) -- a measure of internalized homophobia that was developed specifically for lesbian women (rather than for use on gay men then extended for use in a lesbian population as is often the case; Szymanski and Chung, 1998) – this study examined IH as it relates specifically to health care utilization. However, given the possibility that individual differences in health care utilization may be a function of the degree of (dis)comfort with or the perceived approachability of HCPs rather than of level of IH, the Approachability of Family Practice Consultations Scale (AFPC; Hackett & Jacobson, 1995) was also used. This scale was included to extract

from the level of IH any variability in health care utilization that may be more accurately attributed to factors associated with perceived approachability of HCPs, and thus acted as a control variable.

An additional goal of this research was to examine the effect of adherence to feminist ideology on health care utilization. Feminist identification and participation in the lesbian and/or feminist communities is believed to increase awareness of societal oppression and potentially to cultivate a sense of self-advocacy. Some authors have suggested that being active in feminist or lesbian communities and/or being feminist identified may also work effectively to decrease the experience of internalized homophobia. Women vary in the degree to which they will apply the 'feminist' label to themselves, as well as in their support of feminist tenets. To most fully determine a participant's position in relation to feminism several measures of feminist identity were included in this study. Initially, participants were asked if they consider themselves to be a feminist (yes, no, and not sure, response alternatives were provided). The Attitudes Toward Feminism and the Women's Movement Scale (FWM) developed by Fassinger (1994) was used to assess adherence to feminist ideology. The women were also asked to choose from among a series of seven statements that progress from being representative of an anti-feminist perspective to being representative of a feminist activist perspective, one statement that best described themselves in relation to their feelings or beliefs about feminism (Myaskovsky & Wittig, 1997). Lastly, in an attempt to access information about level of participation in feminist activities or behaviours, the Collective Action Scale (CAS) as adapted by Foster and Matheson (1995) was used.

Although assessing the differential influence of level of IH and feminist identification on health care utilization is the primary objective of this study, the type of HCPs (traditional or non-traditional) that women chose to visit was also investigated. We attempted to determine whether provider-choice varied as a function of IH or of feminist

identification. Participants were asked to supply information about their utilization history for a variety of different traditional and non-traditional HCPs. Additionally, since feeling capable of influencing one's own 'health outcomes' could conceivably influence one's health seeking behaviour, as well as one's choice of provider, The Perceived Health Competence Scale (PHCS), (Smith, Wallston, & Smith, 1995), was included to allow for statistical control of individual variations in perceived competence.

Summary of Hypotheses

Utilization of health care

1. Women who reported a higher degree of IH would utilize the health care system less often than those who reported less internalized homophobia.
2. Women who are more feminist identified will utilize the heath care system more regularly (e.g. will follow preventive care standards more closely) than will those women who are less feminist identified.

Type of care

3. It was also expected that higher rates of IH will be associated with more non-traditional care usage than will lower rates of IH.
4. Feminist women were also expected to seek non-traditional care more often than less feminist identified women. Note that although a different rationale underlies the reasoning, increased use of non-traditional health care providers is predicted for both women that score high on IH, and for those that score high on feminism. It is expected that high IH women will seek alternative care rather than traditional care, while feminists would seek alternative care as a way to participate more fully in their own health care essentially using it as an adjunct to traditional care.

CHAPTER II

Method

Participants

Of the 428 survey packages distributed 162 were returned, for a response rate of 37.9%[6]. Inclusion criteria for this study were that the women self-identified as "lesbian" or as "gay" or that they reported that their current sexual experience was restricted to women. Women who did not meet these criteria (n = 5) were excluded from the analyses. Thus, the final sample consisted of 156 women, the majority (85.3%) of whom self-identified as lesbian (n = 133). An additional 12.2% (n = 19) self-identified as gay, with the remainder (n = 4) indicating that they were unsure or that they identified as bisexual but that their recent experience was exclusively with women. Examination of gender history of sexual experiences indicated that 19.9% (n = 31) of the women reported that their sexual experiences have been exclusively with women. The majority (66.7%) indicated that their experiences were initially with men but then with women. Two women (1.3%) said their experiences were with both sexes, and 19 women (12.2%) reported another pattern. The sample was not ethnically diverse, the majority (96.2%) of the participants were White. Only 1.9% (n=3) of the participants were women of colour, and the remaining 1.9% (n=3) did not indicate their ethnicity or simply indicated that they were "Canadian." The participants ranged in age from 18 to 61 with a mean age of 37.87 years (SD = 8.41).

The majority (63.5%) of the women reported that they received questionnaire packages from members of their friendship networks. Of the remaining participants, contact was made through Canadian media (17.9%), coworkers (5.8%), organizations (4.5%), or "other" (7.1%) means. Women from Ontario comprised the majority (76.3%) of the sample. The western provinces (Alberta and British Columbia) accounted for an

additional 17.9%, Manitoba for 2.6%, Quebec for .6%, and the eastern provinces (New Brunswick, Newfoundland, and Prince Edward Island) for 1.8%.

Participation in this study was voluntary. All participants received a pen as a token incentive with their questionnaire packages. They were treated in accordance with the ethical standards of the Canadian Psychological Association and the American Psychological Association.

Measures

Demographic, Descriptive, and Health Care Information

Demographic and descriptive information

A demographic questionnaire was designed specifically for this study. Information was requested for age, occupation, province of residence, race/ethnicity, level of education, income (personal and household), living arrangements (Senn & Dzinas, 1996), sexual orientation, relationship status (Senn & Dzinas, 1996) and satisfaction, self- identification as a feminist, position on feminist continuum statements (Myaskovsky & Wittig, 1997), past heterosexual experience (voluntary or involuntary), gender pattern of lifetime sexual partners, whether they were currently or had ever been pregnant, and if they had any children (adopted, biological, or step) or planned to have children by any means in the future. Participants were also asked where they obtained information about the study (see Appendix A).

Health and health seeking behaviour

Various types of health information were also collected. Participants were asked to rate their current health status, and their current health compared to other women their age. Both questions were rated using a five-point scale ranging from (1) *poor* to (5) *excellent*. They were also asked to rate their current health compared to their health five years ago. This was also measured on a five-point scale ranging from (1) *a lot less healthy now* to (5) *a lot more healthy now*. Information was also sought regarding the

length of time since their last visit to a HCP, reason for the last visit, the approximate number of days lost from work per year, and the presence of any existing medical conditions or prior surgeries. Participants were asked if they currently had a primary health care provider, and if so, had they disclosed their orientation to that provider (Johnson et al., 1981). Responses include: *yes, I volunteered the information without being asked; yes, I told when I was asked; I was asked but did not reveal this information; No, I have not told but I would like to; No I have not told and would prefer not to; and other* (Johnson et al., 1981) (see Appendix A). Responses to this item were then recoded into a dichotomous variable that indicated whether respondents had disclosed their sexual orientation to their primary care provider or whether they had not disclosed this information.

Participants were asked about the extent of their experience, their frequency of contact, and their level of satisfaction with each of eleven types of health care providers. Two additional categories were included to allow participants to specify other types of providers that they may see for care, but that were not included on the list. The responses (1) *never*, (2) *only when in severe need*, (3) *only during periods of illness or injury*, (4) *as often as recommended for preventive health practice*, and (5) *more often than recommended for preventive health practice* were provided. From the list of HCPs participants were asked to specify what type(s) of HCPs they currently saw, what type they saw specifically for check ups and routine care, what type(s) they saw most often, what type they saw the last time they saw a HCP, what type (if any) they considered their primary care provider, and what providers (if any) had they disclosed their sexual orientation to (see Appendix A). Information gained from this section provided the basis for determining patterns of traditional versus non-traditional health care usage, as well allowing for the calculation of health care utilization rates. Responses were analyzed both by provider type and by frequency and were used as criterion variables. Responses

were recoded to reflect whether participants had utilized the specific provider type, and if they had whether they saw them only episodically (i.e., when in severe need or when ill or injured), or whether they saw them as, or more often than recommended for preventive health practice.

Preventive care was subdivided into two categories – health seeking behaviour from HCPs and self-care. To determine the extent to which the women saw HCPs specifically for preventive care, information was collected on frequency of receiving complete physical examinations, gynecologic examinations, Pap smears, clinical breast examinations, and mammography screening (for women over 40 years of age)[7] over the last five years. Response categories range from *never* to *at least once a year* and were summed to provide a health seeking behaviour score. An additional scale was used to determine the frequency with which women participate in various health behaviours. Both health seeking (i.e., monitoring of cholesterol levels, blood pressure) and self-care behaviours (i.e., regular exercise, healthy diet) were included. Participants were asked how often they performed each of the listed behaviours. Response categories include, *never*, *rarely*, *sometimes*, *frequently*, and an additional category that allows the participants to indicate that they participate in the target behaviour, *as often as suggested* (see Appendix A). Question instructions included a description of how recommended frequencies varied with the specific target behaviour. This measure also allowed the assessment of health care utilization rates as well as provided a measure of perceived compliance with recommended preventive care standards.

Ten additional items were included for descriptive purposes and to allow for comparisons with other research findings (see Appendix A). The virtual absence of validated scales to measure these concepts necessitated this action. Single-item measures were reproduced in a 5-point Likert scale form with responses ranging from *very untrue of me* to *very true of me*. Four of the items assessed avoidance of health

care seeking behaviour (i.e., I often put off seeking medical care when I need it) (Kunkel & Skokan, 1998). Two of the items asked about disclosure-related issues (i.e., I am very careful about which health care providers I tell about my sexual orientation) (Tiemann et al., 1998). Two of the items asked about negative experiences in health care interactions (i.e., I have experienced negative reactions by health care providers because of my sexual orientation) (Robertson, 1992; Stevens, 1992). The remaining two items asked about the participant's perceptions of HCP level of knowledge about lesbian health issues (Johnson & Palermo, 1984; Matthews, 1998) and about belief in an overall holistic attitude toward health (Astin, 1998).

Internalized Homophobia Measure

Assessment of participants' level of internalized homophobia was achieved through the use of Szymanski and Chung's (1998) Internalized Homophobia Scale for Lesbians (IHSL) (see Appendix B). The 52 item IHSL was developed specifically for use with lesbian women. The scale is composed of five subscales that address distinct dimensions of internalized homophobia: "(a) connection with the lesbian community: isolation versus social support; (b) public identification as a lesbian: fear of discovery and passing versus disclosure; (c) personal feelings about being a lesbian: self-hatred versus self-acceptance; (d) moral and religious attitudes toward lesbianism: condemnation versus tolerance and acceptance; and (e) attitudes toward other lesbians: horizontal oppression/hostility versus group appreciation" (Szymanski & Chung, 1998, p. 2). Items were measured on a 7-point Likert scale from strongly disagree to strongly agree with higher scores indicating a higher level of internalized homophobia. The total IHSL is highly reliable (Cronbach's alpha = .94) and was significantly correlated with self-esteem as measured by the Rosenberg Self-Esteem Scale (r = -.255, p < .001) and with loneliness as measured by the Revised UCLA Loneliness scale (r = .406, p < .001) in the expected directions.

Feminism Measures (continuous variables)

Feminist identification was assessed using the Attitudes Toward Feminism and the Women's Movement Scale (FWM) developed by Fassinger (1994) (see Appendix C, items 1-10). Items in this scale are measured on a 5-point Likert scale ranging from strongly disagree to strongly agree with higher scores indicating a more feminist identification. The total FWS has high reliability (Cronbach's alpha = .89). Convergent validity was also high as the FWS scale was significantly correlated with the Attitudes Toward Women Scale (Spence, Helmreich, & Stapp, 1973, as cited in Fassinger, 1994, r = .77, p < .01) and with the short form Attitudes Toward Feminism Scale (Smith, Ferree, & Miller, 1975, as cited in Fassinger, 1994, r = .71, p < .01).

In order to obtain a behavioural measure of the collective action component of feminism the Collective Action Scale (CAS) as adapted by Foster and Matheson, (1995) was used (see Appendix D). This scale was used to assess the degree to which the women participated in, or performed, a variety of feminist activities or behaviours. Participants were instructed to place a check mark next to all of the actions (out of a list of 25) that they have done in the past year. The total number of actions checked were used as a simple behavioural measure of feminism and collective action. While recognizing that the actions included in this scale are not of equal weight with respect to being illustrative of feminist behaviour yet are all counted as one point toward the total, this measure provided information relative to individual differences in participation.

Control Variables

The Perceived Health Competence Scale (PHCS), an adapted version of a "general measure of perceived competence" (Smith et al, 1995, p. 53), is an eight item measure designed to assess "the degree to which an individual feels capable of effectively managing his or her health outcomes" (Smith et al., 1995, p. 51) (see

Appendix E, items 1-8). Items are measured on a 5-point Likert scale with responses that range from strongly disagree to strongly agree where higher scores indicate a greater perception of competence. The authors reported that over a series of five studies on different populations the alpha coefficients ranged from .82 to .90, thus demonstrating high internal consistency. The PHCS was also found to significantly correlate with a single 4-point measure (excellent, good, fair, poor) of self-rated health status (r = -.55 to -.42, p. < .001).

To assess degree of comfort with and perceived approachability of HCPs the Approachability of Family Practice Consultations (AFPC) was used (Hackett & Jacobson, 1995). Three changes to this scale were made to adapt it for use in this study. First, only two of the subscales were retained for use (the doctor, and emotions). The third (the consultation environment) assessed an aspect of the health care interaction that was not relevant in this study. Secondly, the scale was improved by changing it from a dichotomous (agree/disagree) measure to a 5-point Likert scale ranging from strongly disagree to strongly agree. Finally, the term "doctor" was replaced with "health care provider" because in this study type of HCP was a variable that was expected to encompass a wider range of practitioners than just family practitioners or traditional medical doctors. For example, if an item originally read "I raise all of the issues I want to with my doctor" it was changed to read "I raise all of the issues I want to with my health care provider." Retaining two subscales resulted in a 9-item measure, that for the purpose of this study, was used as a single measure (see Appendix E, items 9-17). The *doctor* subscale included five statements that assessed factors directly relating to the doctor as part of the health care consultation experience (e.g., my doctor takes a real interest in me). The *emotions* subscale related more specifically to feelings or emotions that may be experienced by individuals when considering going to the doctors (e.g., going to my doctors is always stressful). Psychometric properties beyond factor structure

and loadings as a result of the reported Principle Component Analysis with Varimax rotation, were not reported given the preliminary stage of scale development. Even if reliability and validity data had been reported, changing the response structure from a dichotomous to a 5-point scale would have affected the ability to do comparisons. Internal reliability was established prior to using the measure in analyses.

Outness Measures

Disclosure of sexual orientation in one's life was measured in two different ways. An overall outness measure adapted from Herek, Cogan, Gillis, and Glunt (1998), was used to determine the extent of disclosure with respect to ten classifications of people or groups of people (see Appendix C). Participants were asked to what extent they have disclosed their sexual orientation to each of the people, or groups of people, on the list. The list included, mother, father, siblings, grandparents, boss, co-workers, neighbours, heterosexual friends known before coming out, heterosexual friends known after coming out, and gay and lesbian friends. Responses could range from (0) *out to none of them* or *not at all*, to (10) *out to all of them* or *completely*. A *not applicable* response category was also provided to allow participants to indicate that a particular category did not apply to them (e.g., parents may be deceased, or respondent may not have siblings). Scores were totaled and then divided by the number of categories to which each participant responded to arrive at a total outness score.

Additionally, a measure conceptualized as a network-sector "closeting" measure by Caron and Ulin (1997) provided "scores of closeting for four different sectors of the respondents' networks" (p. 415). For this study the network sector *friends* was further subdivided to make a distinction between lesbian or gay friends, and heterosexual or straight friends. For each of four questions respondents were asked to indicate on a 9-point scale ranging from *strongly agree* to *strongly disagree*, their level of agreement with respect to each of the five different groups of people. The items measured extent of

disclosure, perceived supportiveness, degree of comfort expressing affection to a partner in the presence of target others, and degree of inclusion of partner in social activities with target groups (see Appendix F). The score for each of the five network sectors was summed across the four questions to provide a closeting score for each sector for the scale. Scores could range from a low of five (indicating very closeted) to a high of 36 (indicating not closeted). The authors report that the alpha's for this scale ranged from .78 to .84.

Procedure

Potential participants were recruited through a snowball sampling technique (accessing, in person or by email, the social networks of the researcher and her advisor), contact with lesbian community organizations (e.g., leisure clubs, church, campus, union, or political groups), or through specialized Canadian media (e.g, radio broadcast, electronic listserves, lesbian/gay publications)[8]. Contact sites were provided with information about how their members/readers may participate in the study. Representatives of the Canadian lesbian/gay media Queer FM, Xtra (Toronto), and Capital Xtra (Ottawa) were asked to consider including information about the survey and how to obtain a copy of the survey in one issue of their publication or in the case of Queer FM, in one broadcast. All those contacted agreed to provide the information.

Potential participants were told that the study was an examination of Canadian lesbian health care practices and social attitudes. If the women agreed to participate they were mailed or given a questionnaire package. Women were also asked to take additional packages to distribute among their own family and friendship networks. Further, a contact phone number, an address, and an email address were provided on the cover letter that indicated how women could request additional copies of the survey if they thought they knew any lesbian women who may be interested in participating in the study.

A total of 428 survey packages were distributed. Each questionnaire package contained a cover letter (see Appendix G), a consent form (see Appendix H) with the bottom portion containing a request for results of the study upon completion, the demographic questionnaire, the remaining scales and information forms, a pen, and a postage paid return envelope addressed to the researcher in care of the Psychology Department at the University of Windsor. Participants were instructed to keep the consent form for their own future reference. Return of a completed package constituted consent.

The cover letter which accompanied each survey package offered personal information about the principal researcher as well as provided a rationale for the study. The purpose of providing personal information was to attempt to alleviate any concerns or suspicions that potential participants may have had with the researcher's intentions.

CHAPTER III

Results

Preliminary Analyses

Descriptive Statistics

An underlying philosophical objective of this study was to acknowledge within group variability. To this end, a comprehensive analysis of demographic and descriptive variables was performed. Means and standard deviations were calculated for the continuous demographic and descriptive variables. Included were age, length and level of satisfaction with current relationship, self-rated current health, self-rated health compared to other women of the participant's age, current health compared to health five years ago, length of time since last visit to HCP, days of work missed annually due to illness, life outness measure, and network sector closeting measure (see Table 1).

The highest level of education completed was high school for 35.9% of the sample, a college or university degree for 39.1%, a Masters degree for 17.3% of the sample, with the remaining 7.7% holding Doctoral or Professional degrees. Personal income ranged from 23.9% of the sample reporting earning less than 30,000 dollars annually, the majority (53.9%) earned from 30,000 to 60,000 dollars, 19.2% reporting income as between 60,000 to 90,000 dollars, and the remaining 2.5% reported annual incomes of more than 90,000 dollars.

Variables that were assessed on a yes, no, or not sure scale included; feminist self-identification, involvement in a committed relationship, having a primary HCP, disclosure of orientation to primary HCP, current pregnancy, past pregnancy, have children, plan children, voluntary sexual intercourse with a man, and involuntary sexual intercourse with a man. These frequencies are reported in Table 2.

The majority (71.8%) of women chose to seek routine care from traditional HCPs. Twenty-three women (14.7%) saw both traditional and nontraditional providers for

Table 1

Means and Standard Deviations of Demographic and Descriptive Variables

Variable	M	SD	Min.	Max.
Age	37.87	8.41	18	61
Length of relationship (mos.)	64.90	51.02	2	240
Satisfaction with relationship (1 = very dissatisfied to 5 = very satisfied)	4.39	.93	1	5
Days of work missed per year	3.96	4.43	0	36
Time since last visit to HCP (mos.)	4.90	8.05	.10	72
Self-rated current health (1= poor to 5 = excellent)	3.74	.86	1	5
Self-rated health compared to others (1= poor to 5 = excellent)	3.68	1.00	1	5
Self-rated health compared to 5 years ago (1 = a lot less healthy now to 5 = a lot more healthy now)	3.12	1.08	1	5
Life outness (0 = not at all to 10 = completely)	7.18	2.42	.56	10
Closeting score (range 20 - 180) (higher scores reflect greater outness)	137.68	26.34	44	180

Table 2

Frequencies of Demographic and Descriptive Variables

	Yes		No		Not sure	
Variable	N	(%)	N	(%)	N	(%)
Feminist self-identification	105	(67.3)	40	(25.6)	11	(7.1)
In a committed relationship	115	(73.7)	39	(25)	1	(.6)
Has a primary care provider	131	(84.0)	25	(16.0)		
Out to primary provider	97	(62.2)	36	(23.1)		
Currently pregnant	0	(0)	155	(99.4)		
Ever pregnant	43	(27.6)	112	(71.8)		
Has children	34	(21.8)	121	(77.6)		
Plan children	27	(17.3)	61	(39.1)		
Has had voluntary intercourse with a man	129	(82.7)	27	(17.3)		
Has had involuntary intercourse with a man	55	(35.3)	101	(64.7)		

routine care, four (2.6%) saw only nontraditional, and 8 (5.1%) did not see anyone for routine care. Most of the women (79.5%) indicated that their primary care provider was a traditional provider.

Participants were asked to indicate which of the providers they had disclosed their sexual orientation to. Approximately one quarter (25.6%) of the women reported that they were not out to any of the providers that they see. Slightly over half (55.8%) of them indicated that they were out to some (but not all) of the providers they see, and twenty-four women (15.4%) reported that they were out to all of them. Participants were also asked to list the reason that they sought health care during their last visit to a HCP. Responses were categorized to reflect preventive care, episodic care, chronic care, or other reasons for the visit. The majority (53.8%) sought episodic care, 27.6% sought preventive care, 5.8% went for chronic conditions, and the remaining 17 women (10.96%) indicated reasons that did not fall into these predefined categories (i.e., post-operative care, smoking cessation).

Frequencies for the health care utilization variables self care and perceived adherence to preventive care standards are presented in Table 3. For frequency of utilization of preventive care services over the last five years see Table 4. Additionally, frequencies for the scale of the ten items included in the survey for descriptive purposes are reported in Table 5. To allow for comparison of level of reported satisfaction for the various types of health care providers means, standard deviations, minimum and maximum satisfaction ratings, and the number of participants that utilized each type of provider are provided in Table 6.

Reliability Analyses

Reliability analyses were performed on all scales prior to using them in the primary analyses. Cronbach's alphas were above .80 for all scale totals. The reliability of the modified version of the Approachability of Family Practice Consultations (AFPC)

Table 3

Summary of Health Behaviours on Self-care and Perceived Adherence Scale (PAS)

	Never		Rarely		Sometimes		Frequently		As recommended	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Self care										
Takes vitamins	20	(12.8)	26	(16.7)	49	(31.4)	22	(14.1)	38	(24.4)
Takes herbs	45	(19.2)	30	(19.2)	41	(26.3)	23	(14.7)	16	(10.3)
Exercises regularly	4	(2.6)	26	(16.7)	59	(37.8)	43	(27.6)	23	(14.7)
Eats healthy foods	3	(1.9)	5	(3.2)	41	(26.3)	74	(47.4)	32	(20.5)
Avoids unhealthy foods	9	(5.8)	20	(12.8)	70	(44.9)	47	(30.1)	9	(5.8)
Gets plenty of sleep	3	(1.9)	21	(13.5)	42	(26.9)	69	(44.2)	20	(12.8)
Does breast self-exams	23	(14.7)	49	(31.4)	43	(27.6)	21	(13.5)	19	(12.2)
PAS										
Physical exams	13	(8.3)	39	(25.0)	25	(16.0)	12	(7.7)	66	(42.3)
Cholesterol checked	57	(36.5)	22	(14.1)	18	(11.5)	9	(5.8)	49	(31.4)
Blood pressure checked	13	(8.3)	27	(17.3)	33	(21.2)	13	(8.3)	69	(44.2)
Mammogram	9	(5.8)	8	(5.1)	4	(2.6)	3	(1.9)	130	(83.3)
Pap smear	13	(8.3)	34	(21.8)	18	(11.5)	14	(9.0)	76	(48.7)
Clinical breast exam	30	(19.2)	28	(17.9)	21	(13.5)	10	(6.4)	66	(42.3)

Table 4

Frequency of Health Care Utilization in the Past Five Years

	Never		Once		Twice		3 times		4 times		At least once a year	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Complete physical	27	(17.3)	32	(20.5)	26	(16.7)	14	(9.0)	13	(8.3)	42	(26.9)
Gynecologic exam	37	(23.7)	26	(16.7)	22	(14.1)	12	(7.7)	15	(9.6)	43	(27.6)
Pap smear	21	(13.5)	28	(17.9)	25	(16.0)	14	(9.0)	17	(10.9)	50	(32.1)
Clinical breast exam	33	(21.2)	31	(19.9)	23	(14.7)	13	(8.3)	12	(7.7)	43	(27.6)
Mammogram >40 yrs. old	24	(37.5)	16	(25.0)	6	(9.4)	4	(6.3)	2	(3.1)	12	(18.8)
Mammogram >50 yrs. old	-	-	1	(7.7)	4	(30.4)	2	(15.4)	-	-	6	(46.2)

Note. Dashes indicate that there were no participants in that cell.

Table 5

Summary of Descriptive Items

	Very Untrue		Slightly untrue		Neutral		Slightly true		Very true	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Avoidance of care										
Avoids going to HCP	61	(39.1)	19	(12.2)	17	(10.9)	35	(22.4)	22	(14.1)
Goes to HCP at first sign of illness *	78	(50.0)	35	(22.4)	16	(10.3)	18	(11.5)	9	(5.8)
Puts off seeking needed care	44	(28.2)	30	(19.2)	17	(10.9)	44	(28.2)	21	(13.5)
Will not seek care unless absolutely needs to	27	(17.3)	37	(23.7)	7	(4.5)	38	(24.4)	46	(29.5)
Disclosure										
Careful about which HCPs they disclose to	49	(31.4)	18	(11.5)	40	(25.6)	21	(13.5)	28	(17.9)
Discloses to all HCPs*	53	(34.0)	22	(14.1)	28	(17.9)	20	(12.8)	33	(21.2)
Negative experiences										
Has experienced negative reactions	74	(47.4)	11	(7.1)	40	(25.6)	22	(14.1)	9	(5.8)
Knows of women who have had bad experiences	51	(32.7)	8	(5.1)	37	(23.7)	29	(18.6)	31	(19.9)
HCP knowledge										
Primary HCP knows about lesbian health	28	(17.9)	14	(9.0)	70	(44.9)	14	(9.0)	27	(17.3)
Holistic philosophy										
Believes body, mind, and spirit are related	7	(4.5)	2	(1.3)	25	(16.0)	23	(14.7)	99	(63.5)

* reverse scored

Table 6

Summary of Satisfaction Ratings by Types of Provider

	N	M	SD	Min.	Max.
Nurse-midwife	2	10.00	.00	10	10
Massage therapist	76	8.87	1.26	6	10
Acupuncturist	26	7.96	2.16	1	10
Nurse practitioner	15	7.87	1.88	5	10
Therapeutic touch	15	7.73	2.84	1	10
Chiropractor	73	7.70	2.39	1	10
Physician assistant	8	7.50	2.14	4	10
Family practitioner	151	7.34	2.40	1	10
Herbalist	11	7.27	2.15	3	10
Naturopath	17	7.18	2.60	1	10
OB/GYN	61	7.00	2.69	1	10

scale (Hackett & Jacobson, 1995) was very high (Cronbach's alpha = .94) and thus was included in analyses as planned.

Scoring

Health care utilization

Perceived adherence to recommended preventive care standards and indicated participation in self care were assessed by summing responses to each of the alternatives provided. For the perceived adherence scale (PAS) all responses to the frequency of receiving a mammogram item from women under 40 years of age were recoded to reflect adherence to the recommended preventive care practice. For example, if a 20 year old women responded that they had "never" gone for a mammogram this response was recoded to "as often as suggested" because mammogram screening is not typically recommended for women of that age. Responses by women over 40 years of age were not recoded.

Responses from the frequency over the previous five year period scale (F5) were summed to arrive at a total F5 score for each woman. Because mammography was accounted for in the perceived adherence scale, and because this was a frequency measure with no alternative scoring option for those women for whom this procedure was not recommended, frequency of mammograms was not calculated into the total frequency score.

Type of health care provider

Participants were provided with five response alternatives for all types of providers listed: never (1); only when in severe need (2); only during periods of illness and injury (3); as often as recommended for preventive health practice (4); and more often than recommended for preventive health practice (5). Responses for all types of providers were recoded. If the respondent did not use the target provider type they were assigned a score of zero. If they indicated that they used the target provider type either,

only when in severe need, or when ill or injured they were assigned a score of one. Indicated use of the target provider type as often, or more often, than recommended resulted in a score of two. The recoded values were then summed across type of providers to yield one score for use of traditional care, and one score for use of non-traditional care.

For some analyses further recoding was necessary. Total scores for traditional and nontraditional care were first standardized, or converted to Z-scores. A relative use score was then calculated by subtracting the standardized score for traditional care from the standardized score for non-traditional care. Therefore, a positive score indicated that the participant used nontraditional care more frequently than traditional care. The larger the score, the larger the discrepancy there was between the type of care used. A negative score indicated that the participant used traditional care more frequently than nontraditional, with larger scores again indicating a greater discrepancy. A score of zero indicated that the participant used both types of care to the same extent. Note that this does not allow for conclusions to be drawn for overall health care utilization frequency.

Relationships Among Variables

Measures of feminism

Correlational analyses were performed on the four measures of feminism (feminist self-identification, position on feminist statements, the FWM scale, and the Collective Action Scale). All inter-correlations were significant at $p < .001$. Correlations ranged from a high of $r = .83$, for the correlation between feminist self-identification and position on the feminist statement, to a low of $r = .54$, between feminist self-identification and score on the CAS (see Table 7). In all cases correlations were in the expected direction. A higher feminism score on any one of the feminism variables was associated with higher feminism scores on each of the other feminism measures. Since all feminism

Table 7

Intercorrelations Between Feminism Measures, Outness Measures, Internalized Homophobia Scale for Lesbians (IHSL), and Approachability of Family Practice Consultations (APPC)

Variable		1	2	3	4	5	6	7	8	9	10
1	IHSL	--									
2	AFPC	-.239**	--								
3	Feminist self-identification	-.517**	.030	--							
4	Feminist statement	-.572**	.012	.833**	--						
5	FWM	-.525**	.025	.595**	.697**	--					
6	CAS	-.537**	-.014	.540**	.742**	.560**	--				
7	Life out	-.617**	.094	.437**	.485**	.282**	.406**	--			
8	Closeting	-.624**	.143	.319**	.314**	.223*	.274**	.736**	--		
9	Out to primary	-.332**	.217*	.310**	.363**	.182*	.379**	.453**	.344**	--	
10	Out to HCPs	-.425**	.179	.380**	.473**	.254**	.501**	.521**	.414**	.742**	--

Note. FWM = Feminism and the Women's Movement scale; CAS = Collective Action Scale.
** $p < .01$ (2-tailed)
* $p < .05$

measures are significantly correlated, and the FWM is a proven reliable and valid measure, the FWM total score will be used as the primary feminism measure.

Measures of outness

Correlational analyses were performed on the total outness scale, the closeting measure, whether participant was out to their primary care provider, and whether they were out to other HCPs that they see. All inter-correlations were significant at $p < .001$. Correlations ranged from a high of $r = .74$, between out to primary and out to other HCPs, to a low of $r = .34$, between out to primary and the closeting measure (see Table 7). In all cases a higher level of outness on one measure was positively correlated with more outness on each of the other outness measures.

Relationship among measures of feminism and IH

Correlational analyses were performed on the feminism measures and the IHSL total score. Total level of internalized homophobia was found to correlate significantly ($p < .001$) with all of the measures of feminism. Bivariate correlations ranged from a high of $r = -.57$, between position of feminist statement and score on IHSL to a low of $r = -.52$, between feminist self-identification and score on IHSL (see Table 7). In all cases the higher the degree of feminism the lower the level of internalized homophobia.

Relationship among measures of outness and IH

Correlational analyses were performed on the outness measures and the IHSL total score. Level of internalized homophobia correlated significantly ($p < .001$) with each of the outness measures. Correlations ranged from a high of $r = -.62$, for the bivariate correlation between IH and the closeting measure, to a low of $r = -.33$, for the bivariate correlation between IH and out to primary (see Table 7). A higher outness score was associated with a lower level of internalized homophobia for each of the outness variables.

Relationship between utilization variables

The correlation between the two utilization variables was tested. The frequency of utilization over the last five years (F5) and perceived adherence to preventive care standards (PAS) scales were correlated to such a high degree (r = .82, p < .001) that they were essentially identical. Given this finding and the fact that the reliabilities for both scales were high (> .85), a decision was made to use a single scale for all utilization tests. The PAS was chosen as the utilization measure because of the wider range of health behaviours that are included in this scale.

Primary Analyses

Health Care Utilization

Internalized homophobia and utilization

To test the hypothesis that higher levels of internalized homophobia would be associated with less frequent utilization of health care a regression analysis was performed using the IHSL total score as a predictor and the PAS scores as the criterion. Level of internalized homophobia was found to significantly predict frequency of utilization, R^2 = .06, $F(1,137)$ = 8.23, p =.005, β = -.238. The R for the regression model was significantly different from 0, and accounted for 6% of the variance in PAS scores. Higher levels of internalized homophobia were associated with lower utilization.

To ensure that this finding was not more accurately related to more general feelings about approachability of HCPs, an additional multiple regression analysis was performed on the utilization measure (PAS) while holding AFPC constant. For this analysis AFPC total score was entered on the first block, with IHSL entered on the second block. When controlling for approachability of HCPs, level of internalized homophobia no longer made a significant contribution to the prediction of utilization, R^2_{Δ} = .02, $F(1,134)$ = 3.09, p = .08, sr = -.13. However, AFPC scores predicted a significant amount of variance in PAS scores, R^2 = .24, $F(1,135)$ = 43.40, p = .001, sr = .45 (see

Table 8). Feeling as though your HCP was approachable was associated with increased utilization. Level of internalized homophobia did not add significantly to the prediction of utilization after extraction of the variability accounted for by the AFPC.

To explore the relationship between internalized homophobia and health care utilization further, additional analyses were performed. First, as a result of the finding that the effect of approachability overshadows the contribution of IH to utilization, a decision was made to test whether perceived approachability of HCP mediated the relationship between IH and utilization of health services. Baron and Kenny's (1986) test of mediation was performed. The results were as follows. Independently, both IH, R^2 = .06, $F(1,138) = 8.23$, $p < .005$, and AFPC, $R^2 = .26$, $F(1,148) = 50.72$, $p < .001$ significantly predict utilization. Additionally, the relationship between the two predictor variables is also significant, $R^2 = .06$, $F(1,137) = 8.26$, $p < .005$. The final and determining step of this test of mediation lies in entering both predictors simultaneously. When both IH and AFPC were entered into the regression equation, IH no longer significantly predicted utilization ($p < .081$). Therefore, AFPC is a mediator of the relationship between internalized homophobia and utilization of health services. That is, internalized homophobia does not directly influence health care utilization rates, but rather it works by manipulating the perceived approachability of health care providers which in turn influences utilization.

This is an interesting and valuable finding that leads one to speculate about other potential within group factors that may affect utilization. Central to the assertion that lesbian women underutilize the health care system is the issue of disclosure of sexual orientation. As is shown by the correlation, willingness to disclose is also associated with level of internalized homophobia. Given that a goal of this research was to search for factors that may promote or impede optimal utilization of health care, these relationships were explored. First, the suggestion that disclosure was related to

Table 8

Standard Multiple Regression of AFPC (block 1) and IHSL (block 2) on Perceived Adherence Scale (PAS) and AFPC (block 1) and FWM (block 2) on PAS

Criterion variable	Predictor	B	β	Sr^2	R^2	R	$R^2\Delta$	p
PAS	Block 1				.24	.47		.000
	AFPC	.40	.49	.240				
	Block 2				.26	.51	.02	.081
	IHSL	-2.30	-.14	.017				
PAS	Block 1				.25	.50		.000
	AFPC	.39	.50	.244				
	Block 2				.31	.56	.06	.001
	FWM	.27	.23	.054				

Note. AFPC = Approachability of Family Practice Consultations; IHSL = Internalized Homophobia Scale for Lesbians; FWM = Feminism and the Women's Movement scale

utilization was tested. A oneway ANOVA was performed to examine differences between those women who disclosed to none, some, or all of their HCPs on utilization of health services, as measured by the PAS. Significant group differences were found for utilization, $F(2, 146) = 11.50$, $p < .001$. Means and standard deviations are displayed in Table 9. A Tukey's post hoc test was performed to examine the between group differences more closely. A significant mean difference was found between those who were out to none of their providers and those who were out to some ($p < .001$) and between those who were out to none and those who were out to all of their providers ($p < .001$). Higher levels of outness were associated with increased utilization. The difference between those women who were out to some and those who were out to all of their providers was not significant ($p < .17$). For graphical illustration of group differences on the PAS see Figure 1.

This initial significant finding prompted further investigation. Given the relationship found previously between internalized homophobia, approachability of HCP, and utilization of health services, and given the relationship between disclosure to health care providers and utilization, a decision was made to perform a standard multiple regression analysis with each of the above implicated factors (IH, AFPC, and disclosure to HCPs) entered as predictors and utilization as the criterion. This model predicted 36% of the variance in utilization scores, $R^2 = .36$, $F(2, 128) = 23.82$, $p < .001$. Of the predictors, AFPC made the largest unique contribution, accounting for 19.3% of the variance in utilization. Disclosure status accounted for 6.3% of the variance, and, as expected because of the relationship between IH and AFPC, IH did not add significantly to the predictive ability of the model.

Table 9

Mean Differences on Perceived Adherence Scale (PAS) by Disclosure to Health Care Providers (HCPs)

DV		Out to none (n = 39)	Out to some (n = 86)	Out to all (n = 24)
PAS	M	17.87[ab]	22.58[a]	25.21[b]
	SD	6.61	6.42	5.73

Note. Means with same superscript are significantly different from each other at $p < .01$ in the Tukey's honestly significant difference comparison.

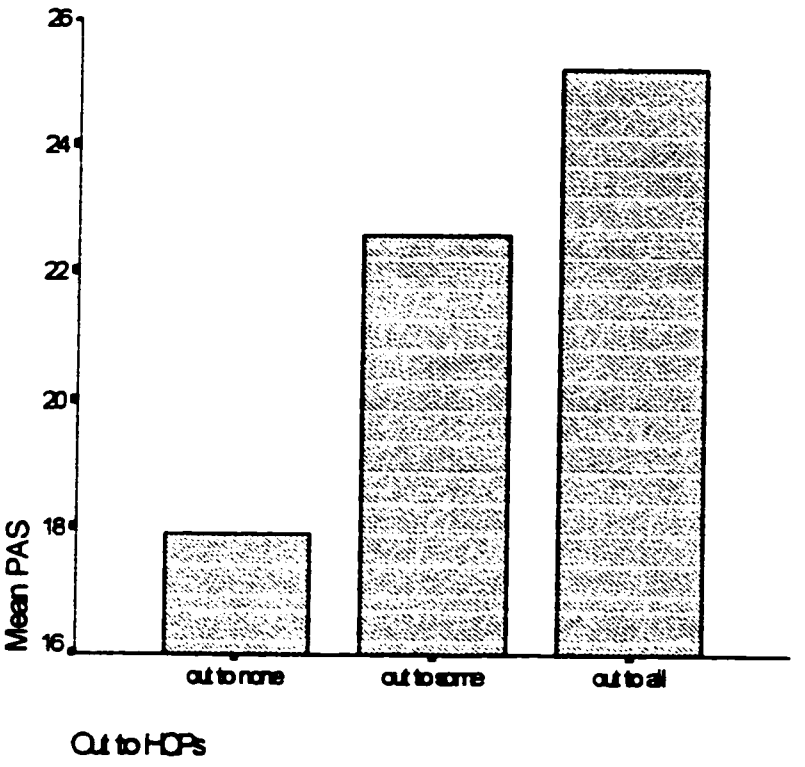

Figure 1

Mean Health Care Utilization Scores by Disclosure to Health Care Providers (HCPs)

Feminism and utilization

To test the hypothesis that women who are more feminist identified would report more frequent utilization of health care a regression analysis was performed using the Attitude Toward Feminism and the Women's Movement scale (FWM) total score as a predictor and the PAS scores as the criterion. Level of feminism was found to significantly predict utilization, $R^2 = .06$, $F(1,140) = 9.09$, $p = .003$, $\beta = .247$. This single predictor model accounted for 6% of the variance in PAS scores. Higher levels of feminism were associated with increased utilization.

This analysis was rerun controlling for approachability of HCP (AFPC). A multiple regression analyses was performed using the PAS as the criterion variable while holding AFPC constant. AFPC total score was entered on the first block, and FWM was entered on the second block. This model significantly predicted 31% of the variance in utilization of health care services, $R^2 = .31$, $F(2,137) = 30.48$, $p = .001$. AFPC scores predicted a significant amount of variance in PAS scores, $R^2_{\Delta} = .25$, $F(1,138) = 47.05$, $p = .001$, $sr = .49$, uniquely accounting for 24%. FWM also made a unique contribution, $R^2_{\Delta} = .05$, $F(1,137) = 10.63$, $p = .001$, $sr = .23$, (see Table 8). When controlling for approachability of HCPs feminism continued to make a unique contribution ($sr^2 = .053$) to health care utilization. This contribution is similar to the contribution of feminism in the single predictor model. Thus very little overlap was found between feminism and approachability with respect to their influence on health care utilization.

Type of Health Care Provider

Internalized homophobia and provider type

To test whether a higher level of internalized homophobia was associated with greater use of nontraditional care a regression analysis was performed using the IHSL total score as the predictor and total nontraditional care usage score as the criterion. Level of internalized homophobia predicted a significant amount of the variance in usage

of nontraditional care, $R^2 = .11$, $F(1,138) = 16.37$, $p = .001$, but in the opposite direction than what was hypothesized ($\beta = -.33$). Therefore, women with higher levels of internalized homophobia utilized nontraditional care less often that those women with lower levels of internalized homophobia.

Nontraditional care has often been identified as a venue that offers more personal control over the health care interaction than does traditional care. To ensure that the variability in the use of nontraditional care by women in this study was not more accurately attributable to a sense of personal control or competence, or that the distributions of IH and perceived health competence significantly overlapped, the analysis was rerun controlling for level of perceived competence as measured by the Perceived Health Competence Scale (PHCS). A multiple regression analysis was performed using nontraditional care as the criterion while holding PHCS constant. PHCS total score was entered on the first block and the IHSL total score was entered on the second block. Perceived health competence was not significant in this model ($p = .48$) and therefore did not alter the relationship between internalized homophobia and use of nontraditional care. Perceived health competence, at least as measured by the PHCS, appears to be unrelated to use of nontraditional care.

Feminism and provider type

To test whether a higher level of feminist identification was associated with greater use of nontraditional care a regression analysis was performed using the FWM total score as the predictor and total nontraditional care usage score as the criterion. Score on the FWM predicted a significant amount of the variance in usage of nontraditional care $R^2 = .06$, $F(1,142) = 8.94$, $p = .003$, in the expected direction ($\beta = .24$). Women who scored higher on the feminist scale used nontraditional care more

often that those women who scored lower on feminism. To compare mean reported use of nontraditional care by feminist self-identification see Figure 2.

This analysis was also rerun controlling for level of perceived health competence. Again, PHCS total score was entered on the first block and FWM total score was entered on the second block. Perceived health competence was also not significant in this model. (p = .85). Entry of the PHCS scores did not detract from the relationship between feminism and use of nontraditional care.

Relative use

To examine participants use of nontraditional care relative to their use of traditional care the standardized relative use variable (nontraditional care Z-score minus traditional care Z-score) was entered as the criterion and separate regression analyses were performed using IHSL total score as the predictor and then using FWM score as the predictor. Both of these analyses were non-significant (p = .074 and p = .228, respectively). Thus the contention that both feminist women and women with higher levels of internalized homophobia would both use more nontraditional care than nonfeminist women and women with lower levels of IH, was not supported. The relative type of care used was not predicted by either feminism or internalized homophobia.

Additional Analyses

Relationship Between Feminism and IH

Past research has suggested (but not tested) that a feminist self-identity may decrease or run counter to level of internalized homophobia in lesbian women. The implications of such a relationship are important, and warrant further attention.

The correlations that exist between measures of feminism and level of internalized homophobia in this study, indicate that feminism and level of internalized homophobia are, if fact, negatively associated. Moreover, both IH and feminism significantly predicted health care utilization in opposite directions. If feminist identity or

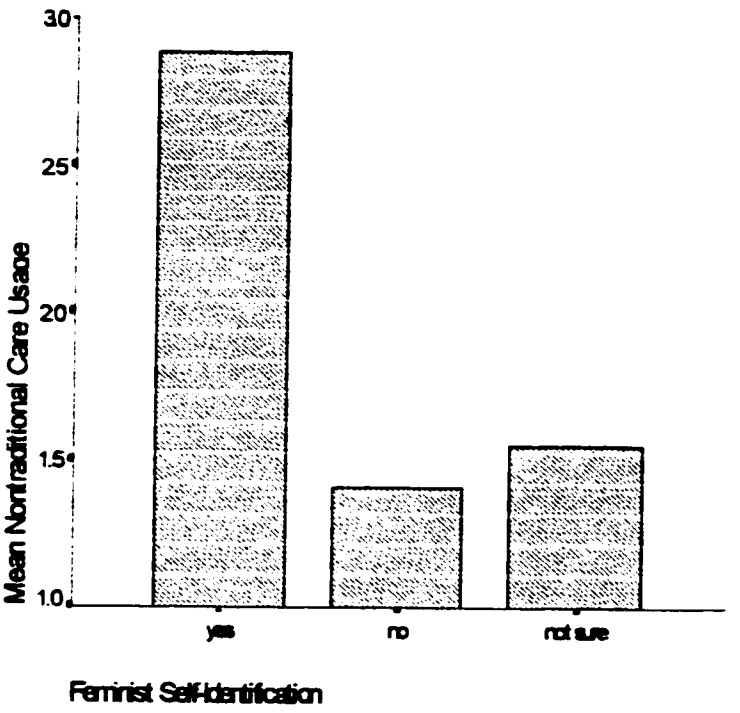

Figure 2

Mean Utilization of Nontraditional Care by Feminist Identification

adherence to feminist ideology predicts lower levels of internalized homophobia, this has profound implications. To test the ability of feminism to predict IH a multiple regression analysis was performed. Given the exploratory nature of this question the stepwise regression procedure was chosen. Feminist self-identification, position on feminist statements, and scores from the Collective Action Scale (CAS) and the FWM scale were entered as predictors. Total score on the IHSL was the criterion. The overall model significantly predicted 38% of the variance in IHSL scores, $\underline{R}^2 = .38$, $\underline{F}(3,126) = 25.46$, $\underline{p} = .001$. The most simple feminism measure (do you identify as a feminist, yes, no, or not sure) did not add to the predictive ability of the model and was therefore excluded. Position on feminist statements predicted a significant amount of variance in IHSL scores, $\underline{R}^2_{\Delta} = .32$, $\underline{F}(1,128) = 58.92$, $\underline{p} = .001$, with a unique contribution of 1.4% ($\underline{sr}^2 = .014$). Scores on the FWM made the highest unique contribution, accounting for 3.5% of the variance in level of internalized homophobia. Participation in feminist activities (CAS) also made a unique contribution, explaining 2.4% of the variance in IHSL score. In all cases the higher the level of feminism the lower the level of internalized homophobia (see Table 10). The three feminism measures together accounted for 38% of the variance in internalized homophobia scores. Further, despite the high inter-correlations between the measures of feminism, three of the four measures contributed a significant amount of the unique variance, thus tapping subtle differences in measurement of feminist expression/identification.

Table 10

Stepwise Multiple Regression of Feminist Measures on Internalized Homophobia Scale for Lesbians

Criterion variable	Predictor	B	β	Sr^2	R^2	R	$R^2\Delta$	p
IHSL	Feminist statement	-4.97	-.21	.014	.32	.56		.000
	FWM	-1.78	-.26	.035	.35	.59	.04	.007
	CAS	-1.41	-.23	.024	.38	.61	.02	.029
	Feminist self-identity							NS

Note. FWM = Feminism and the Women's Movement scale; CAS = Collective Action Scale

CHAPTER IV

Discussion

This study investigated the influence of internalized homophobia (IH) and feminist identification on health care utilization and use of nontraditional health services in a sample of Canadian lesbian women. These results are summarized here, and then discussed in more detail in the context of lesbian health practices. Generally, the results appear to confirm the hypotheses. It was hypothesized that lower levels of internalized homophobia would predict more frequent utilization of health services. This hypothesis was supported. However, after controlling for the effect of perceived approachability of health care providers (HCPs), internalized homophobia no longer significantly predicted health care utilization. Subsequent analyses demonstrated that perceived approachability mediated the relationship between internalized homophobia and utilization.

The hypothesis that higher levels of feminist identification or adherence to feminist ideology would be associated with increased utilization was also supported. Higher scores on the Attitudes Toward Feminism and the Women's Movement (FWM) scale were associated with more frequent utilization of health services. Moreover, feminist identification retained its predictive ability even after controlling for the effect of approachability. Higher levels of feminism predicted higher utilization regardless of how approachable the women felt that their HCPs were.

Additionally, it was predicted that both more highly feminist identified women and women with a higher level of internalized homophobia would use more nontraditional care than less feminist identified women and women with a lower level of IH. In fact, IH was found to significantly predict use of nontraditional care, but not in the anticipated direction. Higher levels of IH were associated with lower levels of nontraditional care usage rather than with higher levels. Therefore, although a significant relationship was

found to exist between IH and use of nontraditional care the hypothesis was not supported. The relationship between feminist identification and the use of nontraditional care exhibited the expected pattern. Higher levels of feminist identification were associated with more frequent use of nontraditional care, as predicted.

Health Care Seeking Characteristics

Given the paucity of health research on Canadian lesbian women, and the goal of this study to explore differences within this group, a wide range of health information was gathered for descriptive purposes. This section summarizes and highlights the findings.

Preventive Care

Seeking regular preventive care promotes physical well-being and, through early detection, aids in disease prevention. Performing regular breast self-examinations (BSE), and receiving regular mammograms (if over age 40), Pap smears, and physical examinations are important parts of maintaining health. Clearly, many lesbian women in this sample did not comply with typical preventive care standards. For example, breast self examinations are recommended monthly and only 12% of the women reported that they did BSE as often as recommended. In fact, nearly half (46%) of the women reported that they rarely or never perform BSEs. Given the increased risk of breast cancer for nulliparious women (AMA, 1996), and the fact that 71.8% of the women in this sample reported never having been pregnant, monthly breast self examinations seem a necessary precaution. Although women in this sample appear not to be following the recommended standard for BSE, their mammogram history appears somewhat more regular. The majority (83.3%) of women reported having mammograms as often as recommended. Only nine women (5.8%) over 40 reported that they had never had one. All women over 50 years of age reported having had at least one mammogram in the

last five years and just under half of the women (46.2%) reported having mammograms yearly.

Additionally, 30% of the women report rarely (21.8%) or never (8.3%) having Pap smears and 13.5% report that they have not had one in the last five years. This result is similar to previously published research by Rankow and Tessaro (1998) who found that 25% of their lesbian/bisexual sample had not had a Pap smear in the three years prior to their survey and 8% had not ever had one at all. Approximately half of the women in the present study reported receiving Pap smears as often as recommended. A history of sexual experience with men factors into STD risk assessment, and should inform disease screening decisions made by HCPs (Edwards & Thin, 1990). For example, O'Hanlan (1995), suggests that some STDs (i.e., syphilis, gonorrhea) are "nonexistent" in lesbian women with no history of sexual activity with men. Therefore, women with no sexual history with men would be fairly safe in avoiding Pap smears. Only 20% of the women reported their lifetime sexual experience to be exclusively with women. Moreover, these women did not significantly differ from women with other sexual history patterns on their reported frequency of receiving Pap smears. So this reluctance to seek Pap smears is not based on accurate self, or HCP, assessment. Knowledge of an individual's sexual identity does not necessarily provide adequate information about past sexual activity. This reaffirms the assertion of many feminist health researchers that HCPs must take a thorough sexual history of all patients to ensure the provision of tailored and optimal care.

Avoiding/delaying Care Seeking

The majority of research on lesbian health has found that many lesbian women avoid or delay seeking health care (Denenberg, 1995; Kunkel & Skokan, 1998; White & Dull, 1997). The results of this study corroborate previous findings, women in this sample also reported delaying seeking care. The majority of women (53.9%) indicated

that it was either slightly or very true that they *will not seek care unless they absolutely need to*. Additionally, 41.7% indicated that they *put off seeking medical care when they need it*, and 36.5% *avoided going to their health care providers*. Given that early detection is critical for positive health outcomes, delaying or avoiding health care could have serious consequences for one's health, and increase the risk that the quality of life may become compromised (O'Hanlan, 1996b). Further, one third of the sample reported that they rarely or never have complete physical examinations. A somewhat larger percentage of women (42%) report having physicals as often as suggested. Again, regular physical examinations are thought to play an important role in early detection and prevention. Therefore, a substantial proportion of lesbian women are at high risk of jeopardizing their health.

Negative Experiences

Mathieson (1998) reported that among the reasons lesbian women cited for avoiding or delaying seeking health care, was prior negative experiences in their health care interactions. Previous research has shown that many lesbian women have both experienced, and expect to experience negative reactions from HCPs upon disclosure of their sexual orientation. In the present study, 19.9% of the women reported that having experienced negative reactions by HCPS was either very or slightly true of their experience. A larger percentage of women (38.5%) reported that they knew of women who had had negative experiences. Overall, 42.3% of the sample have experienced, or have knowledge of negative treatment of lesbian women in health care interactions. These findings are comparable to those found in other studies (31% in Johnson et al., 1981 to 40% in Lehmann et al., 1998).

Disclosure of Sexual Orientation to HCPs

The majority (84%) of women indicated that they had a primary care provider. Of those women 23.1% reported that they had not disclosed their sexual orientation to

them. Overall, 25.6% of the women had not disclosed to any of their HCPs, and 15.4% had disclosed to all of them. Women who were out to their primary care provider were more likely to also be out to other HCPs that they saw.

Utilization of Health Services

Part of the rationale for limiting this sample to Canadian women was to exclude the potential confound of economic concerns (or limitations) on the utilization of health services[9]. Judging by the findings of the present study, economic barriers are clearly not the only barriers to health seeking behaviour.

Internalized Homophobia

Internalized homophobia is commonly understood as the incorporation of society's negative attitudes toward lesbians (and gay men) into one's sense of self. Intuitively, one may expect, and in fact research has suggested, that if a lesbian woman had internalized society's negative attitudes toward lesbians, then feelings of inferiority or shame may affect her life in general and also may manifest themselves in her health seeking behaviour. For example, one may avoid or delay seeking health care out of fear of exposure, or discrimination. Although these reasons have often been cited as contributing to the underutilization of the health care system by lesbian women no published study has explored more general factors that may account for differential utilization rates among lesbian women. Internalized homophobia may be one such overarching factor.

Recently, exploration of the relationship between IH and health care utilization has been called a lesbian health research priority (Patterson, 1998). The present study addressed this priority by using scores on a new internalized homophobia scale (IHSL; Szymanski & Chung, 1998) to predict health care utilization.

Initial analyses showed that as expected, internalized homophobia was found to predict a significant amount of variance in frequency of health care utilization. Higher

levels of internalized homophobia were associated with less frequent utilization of health services. However, further investigation of the relationship between IH and health care utilization, revealed a somewhat more complex picture. Given the lack of published research on the relationship between IH and health care utilization, other factors that may potentially affect utilization were considered. Perceived approachability of HCPs was identified as one such factor. It was predicted that women who underutilized the health care system may do so because they are uncomfortable with HCPs or in health care environments rather than because they are uncomfortable with who they are. To quantify the level of discomfort the Approachability of Family Practice Consultations Scale (AFPC; Hackett & Jacobson, 1995) was adapted for use in this study. Initial changes made to the instrument resulted in a highly reliable scale (Cronbach's alpha = 94).

The AFPC scores were treated as a control variable. That is, they were entered into the regression equation first, on a separate block and IHSL scores were entered afterwards. This was done to extract from the equation any variability in utilization scores that was attributable to perceived approachability, thereby making that variability unavailable to level of internalized homophobia. When the perceived approachability of HCPs was entered into the equation IH no longer significantly predicted utilization of health services. In fact, a lot more variance in utilization scores was predicted by approachability than what was predicted by internalized homophobia initially.

It appeared, at least at this preliminary stage of exploration, that rather than directly affecting the utilization of health services, IH created a more indirect barrier to health seeking behaviour. Thus some evidence was found for the notion that the relationship between internalized homophobia and utilization of health services may more accurately reflect discomfort with HCPs, than discomfort with oneself.

To clarify this relationship a decision was made to test whether AFPC acted as a mediator of the relationship between IH and health care utilization. Baron and Kenny's (1986) test of mediation demonstrated that perceived approachability of HCPs did in fact, mediate the relationship between internalized homophobia and utilization of health services. This finding provides initial support for the contention that rather than directly affecting health care utilization, internalized homophobia creates a psychological barrier to care seeking by manipulating an individuals' concerns and expectations about health care interactions.

Examination of the items on the AFPC scale suggest that factors such as feeling as though your HCP understands you and your health problems, feeling as though you can raise all of the issues that you would like to with your provider, and feeling as though your provider takes a real interest in you, are important for increasing people's willingness to make optimal use of the health care system. The fact that this 9-item scale predicted 24% of the variance in utilization scores speaks well to the importance of feeling that ones' HCP is approachable. This information could be useful at both the health care consumer and the health care provider levels and can potentially be incorporated into health promotion initiatives, education, and research.

That much of the research on underutilization of health services by lesbian women is closely linked to the issue of disclosure of sexual orientation cannot be ignored. Stevens and Hall (1990) suggest that nondisclosure of sexual orientation to HCPs may lead women to feel estranged from health seeking processes and that this lack of connection may result in less frequent utilization. Disclosure in health care environments has also been described as stressful (Matthews, 1998). It is possible that internalized homophobia, particularly in its apparent role of intensifying concerns about health care providers, and therefore perceived approachability of HCPs, may interact with disclosure status to predict health care utilization.

Women who had disclosed to none, versus those who had disclosed to at least some, or all of their HCPs were found to utilize the health care system differently. Women who had not disclosed to any of their providers sought care significantly less frequently than women who had disclosed to some or to all of their providers. That there was no significant difference in utilization between those women who had disclosed to some, and those who had disclosed to all of their providers was not surprising. Admittedly, the importance of disclosure may vary with the type and extent of contact with a particular provider. This finding is similar to the results reported by White and Dull (1998) where women in their sample who had disclosed to their HCPs reported having more Pap smears, and preventive care seeking. Martinson and her colleagues (1996) also found that disclosure was positively related to having physical examinations in the five years preceding their study.

The relationship between disclosure and health care seeking was explored further by assessing the predictive ability of disclosure status while also considering the previously demonstrated relationship between internalized homophobia, perceived approachability of HCPs and health care utilization. Perceived approachability mediated the relationship between IH and utilization by heightening concerns about HCPs. It seemed possible that approachability may also account for the relationship between disclosure and utilization, in that feeling more comfortable with ones' HCP may facilitate disclosure. This, however, was not the case. Thirty-six percent (compared to the 24% predicted with just IH and AFPC) of the variance was predicted by this model. Disclosure status continued to predict utilization, accounting for 6.3% of the variance in utilization. The decision to disclose to ones' HCP appears to go beyond both level of IH and the perceived approachability of health care providers.

Feminism

Despite the logical link that many researchers (e.g., Matthews, 1998) have drawn between utilization of health services, utilization of nontraditional care, and a feminist self-identification or participation in lesbian feminist communities, a lesbian health survey that included an explicit measure of feminism was not found in the published literature. This study attempted to assess feminist identification directly, and explore its relationship to both utilization and use of nontraditional care.

Feminist identification was found to significantly predict utilization of health services. Higher scores on the FWM scale were associated with more frequent utilization. Moreover, feminism remained significant even after the substantial contribution of the AFPC was partialled out. In fact, the unique contribution of FWM scores to the variability in utilization was relatively unchanged by the inclusion of perceived approachability. Consequently, although the variability in health care utilization predicted by IH can be explained by perceived approachability, the variance explained by adherence to feminist ideology cannot. This finding has exciting implications for investigation of the role of feminism on health seeking practices. For example, had the relationship between feminism and utilization been accounted for by perceived approachability as it had for IH, then one could easily assume that feminism is associated with less negative feelings about the approachability of HCPs, and that IH is associated with more negative feelings about the approachability of HCPs. This, however, does not appear to be the case.

If a feminist perspective promotes health seeking behaviour, it may be attributable to the development of increased resilience to what is commonly viewed as a hostile environment (Perkins, 1995). Matthews (1998) suggests that a feminist identity fosters a sense of self advocacy. Perhaps taking good care of yourself is an element of that self-advocacy.

Feminists have been an active and vibrant part of the Women's Health Movement and have played a major role in the redefinition of heath care (Clement, 1987). Women have formed health networks and information networks, advocated a proactive approach to health, and worked toward social change. For example, since 1972 the Vancouver Women's Health Collective has been an advocate for women's health and continues to "lobb(y) to ensure that women have a voice in the health care reform process and [organize] around health issues that affect women" (Vancouver Women's Health Collective, 1999: http://www.weq.gov.bc/general/agencies, p.1). The concept of empowerment is central to feminist ideology (Travis, Gressley, & Adams, 1995). If this results in feminists utilizing the health care system more frequently and appropriately than nonfeminists, then the importance of cultivating a feminist perspective in all women (and girls) is indisputable.

Type of Care

Recent literature has suggested that many lesbian women use nontraditional care providers, rather than traditional care providers, to meet their health needs (Peterson & Bricker-Jenkins, 1992). This study investigated whether use of nontraditional care would vary by either level of IH or by feminist identification.

Internalized homophobia

If traditional HCPs (and related settings) are perceived as hostile (Matthews, 1998), then it is logical to expect that women with higher IH may be more likely than women with lower IH, to avoid traditional care in favour of nontraditional care. Contrary to this expectation, women who reported higher levels of internalized homophobia utilized nontraditional health care less often than those who reported lower levels of internalized homophobia. Therefore, the rationale that women with higher IH may be more likely than women with lower IH, to avoid traditional care in favour of nontraditional care was not supported. Women with higher levels of internalized homophobia appear to

avoid health care regardless of the type. This finding that merits additional attention in future research.

Feminism

The contention that lesbian women use nontraditional health care services more often than other women may, if fact, be more accurately linked to feminist identity rather than sexual identity. The importance of feminist beliefs, or the role of feminism in individual women's lives appears to underlie some of the reasoning used to support recent claims that lesbian women are shifting from using traditional care to using nontraditional care. Self-identification as a feminist and/or adherence to feminist principles presumes a greater likelihood that one is aware of or sensitized to power structures and hierarchies that exist in our culture. Power imbalances may be more apparent in traditional than in nontraditional settings. That "most feminists...value empowerment, internal strength, and self-determination" (Nelson et al., 1997, p. 228), may make nontraditional care an experience that is more in line with their personal beliefs.

The expectation that a feminist self-identity would predict use of nontraditional care was supported. In fact, feminism was associated both with increased use of nontraditional care as well as with increased use of health care generally. In the present sample, women with a feminist identification utilized both types of care more frequently, therefore, the suggestion by the SOGC, that lesbian women may "forego using traditional sources of health care in favour of natural or alternative care" (Canadian Women's Health Network, 1999: `http://cwhn.ca`, p. 1) found no support in this study. In the present study, feminist women were found to use more nontraditional care than were nonfeminist women, but not to the exclusion of traditional care usage. Few women (n = 8, 5.1%) used only nontraditional providers as their primary HCP. The majority

(79.5%) listed traditional providers as their primary provider. Evidence of an alleged shift from traditional to nontraditional providers by lesbian women was not found.

Although this study cannot speak to whether or not lesbian women use nontraditional care more often than heterosexual women, evidence was found for the contention that feminist identified lesbian women use more nontraditional care than nonfeminist lesbian women. The link between type of care used and feminist identification would be an interesting avenue for future research to explore.

The fact that within group differences were found for use of nontraditional care suggests that it is something other than sexual orientation that underlies provider choice. If, in a sample of lesbian women, use of nontraditional care is influenced by feminist identification then it would be reasonable to expect that this may also be true for women regardless of their sexual identity. Generally however, there appears to be a tendency to assume that all lesbian women are feminist women. This is not necessarily the case. As White (1997) explains "many people speak of a lesbian community but in fact what we commonly think of as this 'community' may consist primarily of White lesbian feminists, and many lesbians may not identify with these values" (p. 129). Admittedly, some lesbian samples may have a higher percentage of women who identify as feminist, or that adhere to feminist ideology, than would be the case in a sample of heterosexual women. However, this is more likely to reflect something inherent in the sampling procedure than it is to reflect something inherent in lesbian women. Additionally, for some women, adherence to a feminist perspective may have increased their willingness to disclose, and perhaps may contribute to a decision to live as an out lesbian. We must be careful both to consider the recruitment methods used to gather the sample, as well as to recognize the potential link between being an out lesbian (and therefore more likely to be accessible to researchers) and willingness to participate in research where sexual identity information is collected.

Internalized Homophobia and Feminist Identification

Although no previous research that directly tested the relationship between IH and feminism was found, some have suggested that a negative relationship exists (Downey & Friedman, 1995). Having a feminist perspective, or interactions with the feminist community has been suggested to be incongruous to internalized homophobia. Sophie (1987) contends that reinterpreting what being a lesbian means is an important step toward eliminating feelings of IH. She suggests that challenging the stereotypes of lesbian women is often a starting point. In the present study a feminist perspective was in fact found to be negatively associated with level of IH. Thirty-eight percent of the variance in IH scores was accounted for by a feminist perspective. Downey and Friedman (1995) suggested that with integration into the lesbian communities feelings of internalized homophobia generally tend to dissipate. Results of this study suggest that the same can be said of feminist identification. Participation in lesbian and/or feminist communities facilitate this redefinition and therefore, may well have aided in a new and better understanding of oneself that may include a new awareness of the source of the negative social attitudes toward lesbian women, and perhaps even insight into what motivates this prejudice.

Strengths, Limitations, and Future Research

This study makes an important contribution to lesbian health research. The use of a snowball sampling technique in conjunction with the more frequently used mass access methods potentially increased the diversity of the sample. First, snowball sampling was used to try to access a wide range of women. This method allows access to women who may not, for a variety of reasons, belong to lesbian organizations or participate in lesbian-focused events. Additionally, accessing women through electronic forums, and through a variety of Canadian media allowed for geographic diversity.

By focusing on lesbian women, this study was able to highlight the great deal of variability that exists among this group. This study has acknowledged the diversity of the women in this sample by not treating them as a homogenous group. Moreover, focusing on Canadian women eliminated the potential confound of financial barriers to health seeking behaviour. Although the women in this sample may not have to bear out-of-pocket expenses for traditional care, in most cases they would have to had done so for nontraditional care. The majority (53.9%) of the women in this sample earned between 30,000 to 60,000 dollars annually. Whether this allowed enough disposable income to allow the women to choose nontraditional providers is highly dependent on their individual circumstances. For those women who earned more than 60,000 dollars annually (21.7%), use of nontraditional providers was perhaps a viable option but for those who earned less than 30,000 dollars (23.9%) it probably was not. Perception of affordability of nontraditional care providers (or availability of enhanced health insurance that covers the costs for some types of nontraditional care) was not addressed in the present study. Additionally, the present study did not request information on the criteria on which these women chose their providers, nor did it ask about the availability of nontraditional care in the participant's region. We are, therefore, unable to exclude the possibility that, at least for some women, use of nontraditional care may have been reflective of availability, rather than of personal preference.

Most important, this study explored two previously untested factors that may contribute to utilization of health services. At least one of the factors -- feminist identification -- is not limited to lesbian women. The explicit measurement of feminism allowed both for the detection of a specific link between feminist identity and health care utilization, and for clarification of the patterns of use of nontraditional care among lesbian women. Future research in this area is warranted. It would, for example, be exciting to

investigate the effect of feminist identification on the health care utilization rates of other groups of women.

Unfortunately, the results of this study cannot be generalized to the experiences of all lesbian women but can only speak to the experiences of White women. The near absence of women of colour in this sample makes clear the necessity to actively seek, and selectively recruit women from all cultural and ethnic backgrounds.

This study has revealed several possible areas that would benefit from further investigation. For example, the finding that perceived approachability of HCPs mediated the relationship between IH and health care utilization but not the relationship between feminism and utilization or disclosure and utilization is open to more extensive examination. It would also be interesting to see if perceived approachability predicted health care utilization in other populations.

Finally, a qualitative analysis of the relationship between a feminist perspective and both health care utilization and use of nontraditional care would be certain to yield valuable information. Researchers could ask women if they feel that feminism plays a role in their health seeking behaviour, and if so what type of role do they see it as playing. Does feminism work through inspiring a sense of self-advocacy and developing a mindset that places your own well-being at the forefront or through some other, perhaps more subtle means?

Conclusion

The primary purpose of this study was to explore differences among lesbian women in search of predictors of risk and resilience, and ultimately, to gain information that can be used to promote optimal utilization of our health care system and thereby improve the health of women. Two previously untested factors have both been shown to influence health seeking behaviour.

It appears, at least preliminarily, that a feminist identity fosters, and internalized homophobia impedes, optimal utilization of health services. Internalized homophobia, through manipulation of concerns about health care providers, negatively affects health care utilization and therefore feeds susceptibility by inhibiting care-seeking behaviour. Conversely, feminism increases utilization and therefore fosters resilience through facilitating more regular use of health services.

These findings offer a new perspective from which to explore health care utilization. Feminist identification while clearly offering a fertile avenue for future research, also provides a potential inroad to improving health maintenance. It is important to continue to work toward dispelling the negative connotations of feminism that seem to exist in today's culture and promote a perspective that facilitates a healthy body and mind. The present study also demonstrates how higher levels of feminism are associated with lower levels of internalized homophobia. For this reason alone the adoption of a feminist perspective is valuable. Many of the reasons that lesbian women underutilize the health care system are rooted in the societal and structural realities that create unsafe environments. This can arguably be best attacked through the combination of a feminist identity and collectivism which is often instrumental in developing a sense of empowerment, and indeed of power, on a personal level.

Endnotes

1. Throughout this paper you will notice repeated reference to "lesbian women" or in some cases "women" to refer only to lesbian women. To those who would argue that the term "lesbian women" is redundant, I offer this in the way of explanation for my choice. Research, as a feminist undertaking, must "resist identifying individuals as 'other' than and...resist definitions that identify individuals in relation to the dominant culture" (LeBlanc, 1997, p. 261). It is my belief that to refer to lesbian women as lesbians not only identifies us based solely on our sexuality, but it builds in "otherness."

2. Medline includes "data from over 3,500 major medical journals" (Sell & Petrulio, 1996, p. 36).

3. All of these studies were conducted in the United States. An extensive literature search yielded no comparable large scale Canadian surveys and no references unpublished large scale Canadian research were found. Note however that through the research process, specifically the data collection phase, I have learned that far more research on lesbian health has been and is currently being conducted across Canada. A primary source of this information was the British Columbia Centre for Excellence in Women's Heath (BCCEWH). BCCEWH is currently developing an inventory of research on lesbian health which has been done in Canada.

4. After separating responses based on the gender of the provider she found that the majority (92%) of the recounting of incidents with male HCPs were negative, while less than half (44%) of the stories involving female HCPs were negative.

5. Criticisms of the term homophobia extend to the notion of internalized homophobia. What is really internalized here, it is argued, is an 'anti-homosexual' social mindset (Downey & Friedman, 1995).

6. This response rate is based on the number of surveys returned at the time of analysis. Distribution and collection is still in progress at the time of this writing.

7. Canadian preventive care standards recommend mammography screening for breast cancer for women over 50 years of age (Kathryn Lafreniere, personal communication). Analyses were initially performed using 40 years of age as the standard. Rerunning the analyses using 50 years as the standard did not change any of the results, and therefore the initial analyses are presented.

8. Many of the women who responded to requests made through electronic media requested survey packages for themselves and additional packages to distribute to their friendship and work place networks.

9. Some differences in preventive care recommendations (and therefore medical coverage) exists across provinces. For example, not all provinces will pay for yearly physical examinations.

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APPENDIX A

DEMOGRAPHIC AND HEALTH INFORMATION

For the following questions please write your answer in the space provided.

How old are you?
What is your current occupation?
In what province is your primary residence?

For the following questions please circle the number that matches your choice.

→Where did you get information about this obtaining survey?

1 a friend/acquaintance	3 electronic listserve	5 organization/group (specify) _____
2 newsletter	4 coworker	6 other (please specify)_____

→To what racial or ethnic group do you belong? (If you are biracial please circle all that apply)

1 White/European	4 East Asian/Chinese/Japanese	7 Arab
2 Black/African/Caribbean	5 South Asian/Indian/Pakistani	8 Other (please specify)_____
3 Latin/South American	6 Aboriginal/First Nations	

→What is the **highest** level of education you completed?

1 Elementary school	5 College degree	9 Doctoral degree
2 Some high school	6 University degree	10 Professional degree
3 Completed high school	7 Some graduate school	
4 Some college / university	8 Master's degree	

→What is ***your*** annual income before taxes?

1 Under 14,999	3 30,000 to 44,999	5 60,000 to 74,999	7 90,000 to 100,000
2 15,000 to 29,999	4 45,000 to 59,999	6 75,000 to 89,999	8 Over 100,000

→What is your ***household*** annual income before taxes?

1 Under 14,999	3 30,000 to 44,999	5 60,000 to 74,999	7 90,000 to 100,000
2 15,000 to 29,999	4 45,000 to 59,999	6 75,000 to 89,999	8 Over 100,000

→What are your current living arrangements?

1 Living with parents/siblings	4 Living with partner	7 Other _____
2 Living alone	5 Living with dependent children	
3 Living with roomate(s) (nonsexual)	6 Living with partner and dependent children	

For the following questions please circle the number that best matches your situation.

→Do you identify as 1 lesbian 2 gay 3 bisexual 4 heterosexual 5 not sure

→Do you consider yourself as a feminist? ..... 1 Yes 2 No 3 Not sure

→Are you currently involved in an *intimate* relationship?..... 1 Yes 2 No

→Are you currently involved in an intimate *sexual* relationship?..... 1 Yes 2 No

→Are you currently involved in an intimate *committed* relationship?..... 1 Yes 2 No

→→If you are in a committed relationship how long have you been with your current partner?_____

→→If you are in a committed relationship how satisfied are you with that relationship?

1	2	3	4	5
Very Unsatisfied	Unsatisfied	Neither Satisfied nor Unsatisfied	Satisfied	Very Satisfied

The following group of questions are about your health and about the type of health care providers you see. Please circle the number that best matches your situation.

→Overall, how would you rate your current health?

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

→How would you rate your current health when compared to other women your age?

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

→How would you rate your health now compared to your health five years ago?

1	2	3	4	5
a lot less healthy now	a little less healthy now	about the same	a little more healthy now	a lot more healthy now

→Do you currently have a primary health care provider (someone who you usually go to for routine health care like check ups or physicals or when you get sick)?

1 Yes 2 No

If yes, please answer the following question

Have you told your primary health care provider about your sexual orientation? (please choose ONE of the following responses)

1 Yes, I volunteered the information without being asked

2 Yes, I told him/her when I was asked

3 I was asked, but did not reveal this information

4 No, I have not told him/her but I would like to

5 No, I have not told him/her and I would prefer not to

6 Other (please specify)_____

This is a TWO part question. First, from the following list please circle approximately how often you see or have seen each of the various types of health care providers (please answer for ALL of the types of providers listed). Second, in the last column please indicate on a scale of 1 (very unsatisfied) to 10 (very satisfied) your level of satisfaction with each of the providers you have seen.

Type of provider	never	only when in severe need	only during periods of illness or injury	as often as recommended for preventive health practice	more often than recommended for preventive health practice	1 = very unsatisfied 10 = very satisfied
1 Family practitioner (MD)	1	2	3	4	5	
2 Nurse practitioner	1	2	3	4	5	
3 Nurse midwife/midwife	1	2	3	4	5	
4 Physicians assistant	1	2	3	4	5	
5 Obstetrician/gynecologist	1	2	3	4	5	
6 Chiropractor	1	2	3	4	5	
7 Massage therapist	1	2	3	4	5	
8 Acupuncturist	1	2	3	4	5	
9 Herbalist	1	2	3	4	5	
10 Naturopath	1	2	3	4	5	
11 Therapeutic touch	1	2	3	4	5	
12 Other_____ (please specify)	1	2	3	4	5	
13 Other_____	1	2	3	4	5	

For the following questions please list the number (or numbers if you see more than one type) that correspond(s) to the type of provider from the list above. For example, if you go to a nurse midwife (#3) for gynecologic care and also see a chiropractor (#6) for some other purpose, enter a "3" and a "6" for the first question. Repeat the same process for each of the questions below.

What type of health care provider(s) do you currently see?	
What type of provider do you see for check ups or routine care?	
What type of provider do you see most often?	
What type of provider did you see the last time you saw one?	
What type of provider (if any) do you consider your primary provider?	
Of all of the providers that you see or have seen which ones have you disclosed your sexual orientation to? (also indicate if none)	

→Approximately how long has it been since you last saw a health care provider?_____

→What was the reason for your last visit to your health care provider?_____

→On average, approximately how many days of work do you miss each year because of illness?_____

→Do you have any medical conditions that require you to see a health care provider frequently? 1 Yes 2 No
If yes please specify_____

→Have you had any surgery(ies) in the last five years?
1 Yes 2 No
If yes please specify_____

→Are you currently pregnant? 1 Yes 2 No 3 Not sure

→Have you ever been pregnant? 1 Yes 2 No 3 Not sure

→Do you have children? (include adopted/biological/step). 1 Yes 2 No

If yes please answer the following question

Number of children under 18_____ Number of children over 18_____

If no please answer the following question

Do you plan to, or would you like to, have children (through any means) in the future?

1 Yes 2 No 3 Not sure

The following is a list of different things that people may do as part of their lifestyle. Recommended frequencies vary for the different behaviours. For example, you should eat healthy daily, do breast self-exams monthly, and get physicals yearly. The response category "as often as suggested" means that you follow the recommended guidelines for that particular behaviour. For each of the examples please indicate how often you do each of the behaviours.

Type of behaviour	Never	Rarely	Sometimes	Frequently	As often as suggested
take vitamins	1	2	3	4	5
take herbs for your health	1	2	3	4	5
exercise regularly	1	2	3	4	5
eat healthy foods	1	2	3	4	5
avoid unhealthy foods	1	2	3	4	5
get plenty of sleep	1	2	3	4	5
do breast self-exams	1	2	3	4	5
go for a physical exam	1	2	3	4	5
have cholesterol checked	1	2	3	4	5
have blood pressure checked	1	2	3	4	5
have a mammogram	1	2	3	4	5
have a Pap smear	1	2	3	4	5
have a clinical breast exam	1	2	3	4	5

→Over the last five years approximately (to the best of your memory) how often have you gone to your health care provider for the following procedures?

	Never	Once	Twice	Three times	Four times	At least once a year
a complete physical	0	1	2	3	4	5
a gynecologic exam	0	1	2	3	4	5
a Pap smear	0	1	2	3	4	5
a clinical breast exam	0	1	2	3	4	5
a mammogram	0	1	2	3	4	5

For the following questions please consider your primary health care provider when answering. Please circle the letter(s) in the box that matches your experience.		Very untrue of me	Slightly untrue of me	Neutral	Slightly true of me	Very true of me
1	I avoid going to my health care provider	VU	SU	N	ST	VT
2	I always go to my health care provider at the very first sign that I may be getting sick	VU	SU	N	ST	VT
3	I am very careful about which health care providers I tell about my sexual orientation	VU	SU	N	ST	VT
4	I often put off seeking medical care when I need it	VU	SU	N	ST	VT
5	I will not seek medical care unless I absolutely need to	VU	SU	N	ST	VT
6	I disclose my sexual orientation to all of my health care providers	VU	SU	N	ST	VT
7	My primary health care provider is very knowledgeable about lesbian health issues	VU	SU	N	ST	VT
8	I have experienced negative reactions by health care providers because of my sexual orientation	VU	SU	N	ST	VT
9	I know some women who have had bad experiences with health care providers because of their sexual orientation	VU	SU	N	ST	VT
10	I believe that the health of my body, mind, and spirit are related and whoever cares for my health should take that into account	VU	SU	N	ST	VT

→At any time in your life did you ever voluntarily engage in sexual intercourse with a man? 1 Yes 2 No

→At any time in your life did you ever have sexual intercourse with a man against your will? 1 Yes 2 No

→Since you have been sexually active have your sexual experiences been .... (circle only ONE response)

1 Exclusively with women	5 At first only with men now only with women
2 Exclusively with men	6 At first only with women now with both men and women
3 With both men and women	7 At first only with men now with both men and women
4 At first only with women now only with men	8 Other_____

Please read the following statements and choose the ONE that best describes you (choose only ONE).

1 I do not consider myself a feminist at all and I believe that feminists are harmful to family life

2 I do not consider myself a feminist

3 I agree with some of the objectives of the feminist movement, but do not call myself a feminist

4 I agree with most of the objectives of the feminist movement, but do not call myself a feminist

5 I privately consider myself a feminist, but do not call myself a feminist around others

6 I call myself a feminist around others

7 I call myself a feminist around others and am currently active in the women's movement

APPENDIX B

THE INTERNALIZED HOMOPHOBIA SCALE FOR LESBIANS

For each of the following questions circle the letters that correspond to your own feelings or attitudes		Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1.	Most of my friends are lesbians	SD	MD	SLD	N	SLA	MA	SA
2.	I try not to give signs that I am a lesbian. I am careful about the way I dress, the jewelry I wear, the places, people and events I talk about	SD	MD	SLD	N	SLA	MA	SA
3.	Just as in other species, female homosexuality is a natural expression of sexuality in human women	SD	MD	SLD	N	SLA	MA	SA
4.	I can't stand lesbians who are too "butch" they make lesbians as a group look bad	SD	MD	SLD	N	SLA	MA	SA
5.	Attending lesbian events and organizations is important to me	SD	MD	SLD	N	SLA	MA	SA
6.	I hate myself for being attracted to other women	SD	MD	SLD	N	SLA	MA	SA
7.	Female homosexuality is a sin	SD	MD	SLD	N	SLA	MA	SA
8.	I am comfortable being an "out" lesbian. I want others to know and see me as a lesbian	SD	MD	SLD	N	SLA	MA	SA
9.	I feel comfortable with the diversity of the women who make up the lesbian community	SD	MD	SLD	N	SLA	MA	SA
10.	I have respect and admiration for other lesbians	SD	MD	SLD	N	SLA	MA	SA
11.	I feel isolated and separate from other lesbians	SD	MD	SLD	N	SLA	MA	SA
12.	I wouldn't mind if my boss knew I was a lesbian	SD	MD	SLD	N	SLA	MA	SA
13.	If some lesbians would change and be more acceptable to the larger society, lesbians as a group would not have to deal with so much negativity and discrimination	SD	MD	SLD	N	SLA	MA	SA
14.	I am proud to be a lesbian	SD	MD	SLD	N	SLA	MA	SA
15.	I am not worried about anyone finding out I am a lesbian	SD	MD	SLD	N	SLA	MA	SA
16.	When interacting with members of the lesbian community, I often feel different and alone, like I don't fit in	SD	MD	SLD	N	SLA	MA	SA
17.	Female homosexuality is an acceptable lifestyle	SD	MD	SLD	N	SLA	MA	SA
18.	I feel bad for acting on my lesbian desires	SD	MD	SLD	N	SLA	MA	SA
19.	I feel comfortable talking to my heterosexual friends about my everyday home life with my lesbian partner/lover or my everyday activities with my lesbian friends	SD	MD	SLD	N	SLA	MA	SA
20.	Having lesbian friends is important to me	SD	MD	SLD	N	SLA	MA	SA
21.	I am familiar with lesbian books and/or magazines	SD	MD	SLD	N	SLA	MA	SA
22.	Being a part of the lesbian community is important to me	SD	MD	SLD	N	SLA	MA	SA
23.	As a lesbian, I am lovable and deserving of respect	SD	MD	SLD	N	SLA	MA	SA
24.	It is important for me to conceal the fact that I am a lesbian from my family	SD	MD	SLD	N	SLA	MA	SA
25.	I feel comfortable talking about homosexuality in public	SD	MD	SLD	N	SLA	MA	SA
26.	I live in fear that someone will find out that I am a lesbian	SD	MD	SLD	N	SLA	MA	SA

For each of the following questions circle the letters that correspond to your own feelings or attitudes		Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
27.	If I could change my sexual orientation and become heterosexual, I would	SD	MD	SLD	N	SLA	MA	SA
28.	I do not feel the need to be on guard, lie, or hide my lesbianism to others	SD	MD	SLD	N	SLA	MA	SA
29.	I feel comfortable joining a lesbian social group, lesbian sports team, or lesbian organization	SD	MD	SLD	N	SLA	MA	SA
30.	When speaking of my lesbian lover/partner to a straight person I change the pronouns so that the others will think I am involved with a man rather than a woman	SD	MD	SLD	N	SLA	MA	SA
31.	Being a lesbian makes my future look bleak and hopeless	SD	MD	SLD	N	SLA	MA	SA
32.	Children should be taught that being gay is a normal and healthy way for people to be	SD	MD	SLD	N	SLA	MA	SA
33.	My feelings toward other lesbians are often negative	SD	MD	SLD	N	SLA	MA	SA
34.	If my peers knew of my lesbianism, I am afraid that many would not want to be friends with me	SD	MD	SLD	N	SLA	MA	SA
35.	I feel comfortable being a lesbian	SD	MD	SLD	N	SLA	MA	SA
36.	Social situations with other lesbians makes me feel uncomfortable	SD	MD	SLD	N	SLA	MA	SA
37.	I wish some lesbians wouldn't flaunt their lesbianism. They only do it for shock value and it doesn't accomplish anything positive	SD	MD	SLD	N	SLA	MA	SA
38.	I don't feel disappointed in myself for being a lesbian	SD	MD	SLD	N	SLA	MA	SA
39.	I am familiar with lesbian movies and/or music	SD	MD	SLD	N	SLA	MA	SA
40.	I am aware of the history concerning the development of lesbian communities and/or the lesbian/gay rights movement	SD	MD	SLD	N	SLA	MA	SA
41.	I act as if my lesbian lovers are merely my friends	SD	MD	SLD	N	SLA	MA	SA
42.	Lesbian lifestyles are a viable and legitimate choice for women	SD	MD	SLD	N	SLA	MA	SA
43.	I feel uncomfortable discussing my lesbianism with my family	SD	MD	SLD	N	SLA	MA	SA
44.	I don't like to be seen in public with lesbians who look "too butch" or are "too out" because others will then think I am a lesbian	SD	MD	SLD	N	SLA	MA	SA
45.	I could not confront a straight friend or acquaintance if she or he made a homophobic or heterosexist statement to me	SD	MD	SLD	N	SLA	MA	SA
46.	I am familiar with lesbian music festivals and conferences	SD	MD	SLD	N	SLA	MA	SA
47.	When speaking of my lover/partner to a straight person, I use neutral pronouns so the sex of the person is vague	SD	MD	SLD	N	SLA	MA	SA
48.	Lesbian couples should be allowed to adopt children the same as heterosexual couples	SD	MD	SLD	N	SLA	MA	SA
49.	Lesbians are too aggressive	SD	MD	SLD	N	SLA	MA	SA
50.	I frequently make negative comments about other lesbians	SD	MD	SLD	N	SLA	MA	SA
51.	Growing up in a lesbian family is detrimental for children	SD	MD	SLD	N	SLA	MA	SA
52.	I am familiar with community resources for lesbians (bookstores, support groups, bars, etc.)	SD	MD	SLD	N	SLA	MA	SA

APPENDIX C

THE ATTITUDES TOWARD FEMINISM AND THE WOMEN'S MOVEMENT SCALE

AND

THE LIFE OUTNESS SCALE

For the following questions please circle the number in the box that matches your choice.

➔To what extent have you disclosed your sexual orientation (or "come out") to each of the people or groups of people listed below. Please circle the number that corresponds with your choice.

	(not at all) none of them					about half of them					(completely) all of them	
Mother	0	1	2	3	4	5	6	7	8	9	10	N/A
Father	0	1	2	3	4	5	6	7	8	9	10	N/A
Siblings	0	1	2	3	4	5	6	7	8	9	10	N/A
Grandparents	0	1	2	3	4	5	6	7	8	9	10	N/A
Your boss	0	1	2	3	4	5	6	7	8	9	10	N/A
Co-workers	0	1	2	3	4	5	6	7	8	9	10	N/A
Neighbours	0	1	2	3	4	5	6	7	8	9	10	N/A
Heterosexual friends known before you came out	0	1	2	3	4	5	6	7	8	9	10	N/A
Heterosexual friends known after you came out	0	1	2	3	4	5	6	7	8	9	10	N/A
Gay or lesbian friends	0	1	2	3	4	5	6	7	8	9	10	N/A

For each of the following questions circle the letters that correspond to your own feelings or attitudes		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1.	The leaders of the women's movement may be extreme, but they have the right idea	SD	D	N	A	SA
2.	There are better ways for women to fight for equality than through the women's movement	SD	D	N	A	SA
3.	More people would favour the women's movement if they knew more about it	SD	D	N	A	SA
4.	The women's movement has positively influenced relationships between women and men	SD	D	N	A	SA
5.	The women's movement is too radical and extreme in it's views	SD	D	N	A	SA
6.	The women's movement has made important gains in equal rights and political power for women	SD	D	N	A	SA
7.	Feminists are too visionary for a practical world	SD	D	N	A	SA
8.	Feminist principles should be adopted everywhere	SD	D	N	A	SA
9.	Feminists are a menace to this nation and this world	SD	D	N	A	SA
10.	I am overjoyed that women's liberation is finally happening in this country	SD	D	N	A	SA

APPENDIX D

THE COLLECTIVE ACTION SCALE

→Over the past year how many of these actions did you do? Please read through the list and place a check or an "X" next to all the things that you have done. Please check ALL that apply.

X		Place an "X" next to the number of each action you do or have done.
	1	I have gone out of my way to collect information on women's issues
	2	I don't let anyone treat me differently because I am a woman
	3	If a man acts differently when I'm around because I am a woman, I assure him that it is not necessary
	4	I make a conscious attempt to use non-sexist language
	5	I keep an eye on the views of my members of parliament regarding women's issues
	6	I have attended talks on women's issues
	7	I will correct other's use of sexist language
	8	I have discussed women's issues with family or friends, stressing the need to enhance women's position in society
	9	I have signed a petition advocating the Women's Movement's position on social issues (e.g., pro-choice, pay equity, affirmative action)
	10	I have distributed information on women's issues around campus or work
	11	I have lobbied my member of parliament regarding women's issues
	12	I have volunteered for groups aimed to help women
	13	I have donated money to women's organizations or events aimed at women's issues
	14	I have participated in discussion groups designed to discuss issues or solutions to problems that will benefit women in general
	15	I have written letters to newspapers in instances where I believe it was necessary to speak on behalf of women in general
	16	If, in a group of strangers (i.e., people I haven't known for long or well), a sexist comment is made, I will make a point of arguing against it
	17	I am a member of an organization that deals with women's issues
	18	I have encouraged friends to collect information on women's issues
	19	I have encouraged friends to take classes oriented toward women's issues
	20	I have encouraged friends to join organizations that deal with women's issues
	21	I have participated in protests regarding women's issues
	22	I have organized events that deal with women's issues
	23	I have organized support groups for women (e.g., for those who are re-entering school, or the workforce, for single mothers, etc.)
	24	I have participated in fundraisers, consciousness raising events, etc. that attempt to increase the overall status of women
	25	I have given lectures or talks on women's issues

APPENDIX E

THE APPROACHABILITY OF FAMILY PRACTICE CONSULTATIONS SCALE

AND

THE PERCEIVED HEALTH COMPETENCE SCALE

For each of the following questions circle the letter(s) in the box that corresponds to your own feelings or attitudes.		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I handle myself well with respect to my health	SD	D	N	A	SA
2	No matter how hard I try, my health just doesn't turn out the way I would like	SD	D	N	A	SA
3	It is difficult for me to find effective solutions to the health problems that come my way	SD	D	N	A	SA
4	I succeed in the projects that I undertake to improve my health	SD	D	N	A	SA
5	I'm generally able to accomplish my goals with respect to my health	SD	D	N	A	SA
6	I find my efforts to change things that I don't like about my health are ineffective	SD	D	N	A	SA
7	Typically, my plans for my health don't work out well	SD	D	N	A	SA
8	I am able to do things for my health as well as most other people	SD	D	N	A	SA
9	I raise all of the issues that I want to with my health care provider	SD	D	N	A	SA
10	Being with my health care provider is not stressful	SD	D	N	A	SA
11	My health care provider understands me as a person	SD	D	N	A	SA
12	I do not worry about going to see my health care provider	SD	D	N	A	SA
13	My health care provider takes a real interest in me	SD	D	N	A	SA
14	I do not worry about getting test results from my health care provider	SD	D	N	A	SA
15	My health care provider understands all of the health problems I have	SD	D	N	A	SA
16	Going to my health care provider is always stressful	SD	D	N	A	SA
17	I do not worry about making an appointment to see my health care provider	SD	D	N	A	SA

Thank you for your participation! Please include any additional comments you may have in the space below.

APPENDIX F

NETWORK SECTOR CLOSETING MEASURE

In this section you are asked to respond to a variety of questions with respect to five different groups of people (your immediate family, your extended family, your friends that are heterosexual or "straight", your friends that are lesbian, gay, or bisexual, and your co-workers or people in your workplace). Please indicate your level of agreement with each statement for each of the five different groups by circling the number that corresponds to your choice.

→ 1. The people in (group from below) know that I am a lesbian

	Strongly Agree				Neutral				Strongly Disagree
My immediate family (mother, father, siblings)	1	2	3	4	5	6	7	8	9
My extended family (aunts, uncles, etc.)	1	2	3	4	5	6	7	8	9
My straight (heterosexual) friends	1	2	3	4	5	6	7	8	9
My lesbian, gay, or bisexual friends	1	2	3	4	5	6	7	8	9
My co-workers	1	2	3	4	5	6	7	8	9

→ 2. Those that know I am a lesbian are supportive of this.

	SA				N				SD
My immediate family	1	2	3	4	5	6	7	8	9
My extended family	1	2	3	4	5	6	7	8	9
My straight (heterosexual) friends	1	2	3	4	5	6	7	8	9
My lesbian, gay, or bisexual friends	1	2	3	4	5	6	7	8	9
My co-workers	1	2	3	4	5	6	7	8	9

For the next two questions if you are not currently dating or in a relationship with a woman answer using how you felt in your most recent relationship with a woman. Please check to ensure that you have provided answers for all of the five groups for each of the questions.

→ 3. I do not feel comfortable expressing affection to my partner in front of....

	SA				N				SD
My immediate family	1	2	3	4	5	6	7	8	9
My extended family	1	2	3	4	5	6	7	8	9
My straight (heterosexual) friends	1	2	3	4	5	6	7	8	9
My lesbian, gay, or bisexual friends	1	2	3	4	5	6	7	8	9
My co-workers	1	2	3	4	5	6	7	8	9

→ 4. When I am invited to a social gathering (dinner, holidays, movies, etc.) they invite my partner as well.

	SA				N				SD
My immediate family	1	2	3	4	5	6	7	8	9
My extended family	1	2	3	4	5	6	7	8	9
My straight (heterosexual) friends	1	2	3	4	5	6	7	8	9
My lesbian, gay, or bisexual friends	1	2	3	4	5	6	7	8	9
My co-workers	1	2	3	4	5	6	7	8	9

APPENDIX G

COVER LETTER

University of Windsor/Psychology
401 Sunset Ave.
Windsor, ON
N9B 3P4

Dear Potential Participant,

Being asked to participate in research about lesbian women can sometimes arouse suspicion about the researcher's intentions. I would like to take this opportunity to tell you a little about myself and my research and hopefully ease any concerns you may have.

I am a lesbian, living in a committed relationship with my partner and two teenaged children. I am also a psychology graduate student at the University of Windsor, in my second year of the applied social psychology program. This survey is part of the research I am doing for my Masters thesis. This research will examine lesbian health and social attitudes. While there has been some published research done on lesbian health, almost all of it is from the United States. This study will focus exclusively on Canadian women (citizens or residents) and hopefully will provide us with valuable information from a uniquely Canadian perspective.

If you know any lesbian women (living anywhere in Canada!) that you think may be interested in participating in the study please feel free to leave a message for me at (519) 253-4232, ext. 2217 to request as many additional copies of the survey as you would like. You may also email me at, bewilde@windsor.igs.net or write me at the above address to avoid any long distance charges.

To obtain a copy of the results of this study simply follow the instructions provided on the research consent form.

Thank you for your time!

Sincerely,

Sherry Bergeron
University of Windsor

APPENDIX H

CONSENT FORM

Research Consent Form

Department of Psychology, University of Windsor

The purpose of this research is to examine lesbian health and social attitudes in Canadian women. The information obtained will be used as the basis of a Masters thesis research project carried out by Sherry Bergeron, under the supervision of Dr. Charlene Senn.

Participation in this research project involves responding to the enclosed questionnaire booklet. This will take approximately 30 minutes. No physical, emotional or social discomfort is involved in this task. Participation is voluntary and you may refrain from answering any question that you prefer to omit or stop at any time without penalty.

All information will be kept confidential. Completion and return of the questionnaire package will constitute agreement to participate in the study. A postage paid addressed envelope is included for your convenience.

You may obtain a full report of the research results upon request, by tearing off the bottom portion of this form and mailing it separately from your questionnaire to the address below along with the address where you would like the information forwarded. Mailing the form separately protects the confidentiality of your questionnaire responses. The report will not be ready for at least nine months so please give an address that will still be valid then.

This study has been cleared by the Department of Psychology Ethics committee. Any questions or concerns about the study may be directed to

Sherry Bergeron (principle researcher) 253-4232 ext. 2217

Dr. Charlene Senn (supervisor) 253-4232 ext. 2255

Dr. D. Shore (Chair, Ethics Committee) 253-4232 ext. 2253

Please keep this sheet as a record of your participation and in case you have questions at a later time.

Your participation is greatly appreciated!

If you would like a copy of the results please send the portion below to

Sherry Bergeron
C/O Psychology Department,
University of Windsor
401 Sunset Ave.
Windsor, ON, N9B 3P4

I would like to obtain a copy of the results. Please send it to

NAME _____

ADDRESS_____

POSTAL CODE_____

VITA AUCTORIS

Sherry M. Bergeron was born on February 5, 1961 in Windsor, Ontario. She graduated from the University of Windsor with her Honours Bachelor of Arts in Psychology in 1996. Since 1997 she has been enrolled in the Doctoral Program in Applied Social Psychology at the University of Windsor.